Maryland
STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 7 *July, 1958* NUMBER 7

EDITORIAL

Since January 1952, the Editorial Board of your State Medical Journal has endeavored to provide the members of the Medical and Chirurgical Faculty with a journal that ranks with the best in journals of this type.

Over these years, different features have been introduced. In 1958 we have already seen the introduction of a monthly article by the Maryland Society of Pathologists; and in the July issue we will see a like series by the Heart Association of Maryland.

Also starting in July will be a "Newsletter" to contain up-to-the-minute news that will be of interest to practicing physicians in the State of Maryland. This "Newsletter" will be prepared and edited by the newly appointed executive secretary.

In an attempt to expand its news of interest to members, the Journal is also planning to include obituaries of members, with an "In Memoriam" page devoted to honoring their profession.

Under consideration for future issues of the Journal are: Abstracts of Council Minutes; a column listing various Faculty Committee activities; a "Letters of Interest" column; and a "Noted in Passing" column—devoted to items of interest to physicians of the State of Maryland.

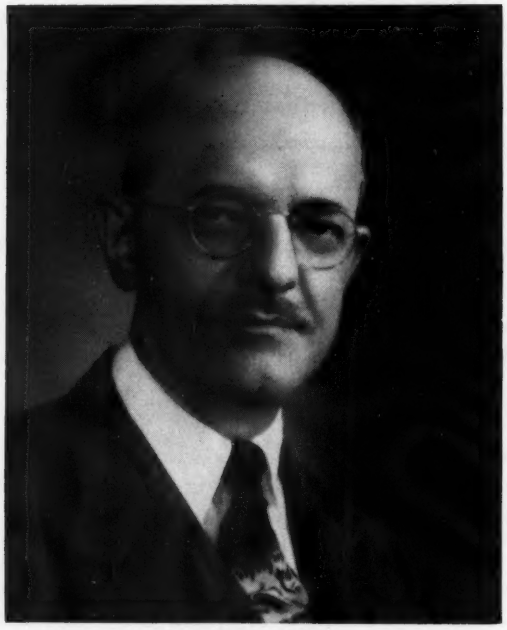
Beginning with the July issue, the cover of the Journal will become glossy white—to conform with the appearance of other State journals published throughout the country.

All of these activities are being considered and discussed to make your Journal as interesting as possible. To completely succeed in these aims, however, we need your suggestions and comments. By letting us know what you want and how you wish it presented, we can develop an infinitely more interesting and worthwhile journal.

The Editorial Board

IN MEMORIAM—GRANT EBEN WARD, M.D. 1896–1958

ALFRED BLALOCK, M.D.



GRANT EBEN WARD

"Yea, though I walk through the valley of the shadow of death, I will fear no evil, for Thou art with me . . ."

Grant Ward passed away on Sunday, February 16, 1958 at the age of 61. The final of his many illnesses was cancer, a disease on which he was an international authority. His physicians informed him of the nature of his illness, just as Grant always made it a practice to tell his patients the truth. Knowing the fatal nature of his own illness, he and his wife, Lillian Hersperger, and daughter, Margaret, spent the Christmas holidays in Minneapolis with daughter, Mary Grace, her husband, and three children. On his return to Baltimore, he described this delightful visit and said he was happy and unafraid and ready to depart this world when the time came. Everyone was so hopeful that this would not be before the meeting of the Society of Head and Neck Surgeons, in Baltimore, in April of this year. Grant was president of this organization and had made extensive plans for the meeting. He will be sorely missed on this and many other occasions.

Grant Ward was born in Lorain, Ohio, received his A.B. degree from Baldwin-Wallace College in 1917 and his M.D. degree from Johns Hopkins in 1921. He had made his decision to become a physician at the tender age of twelve. Following graduation from medical school, he served an internship in Gynecology in the Johns Hopkins Hospital and this experience was followed by five years in close association with the renowned Dr. Howard A. Kelly. While at Kelly's Hospital he designed a lead cylinder for applying radium to malignancies of the surface of the body and more importantly he discovered the hemostatic effects of the electric needle. This latter method

and its modifications has been a tremendous aid in all branches of surgery and particularly neurosurgery. Close ties bound Dr. Kelly and Grant, and Dr. Kelly described him as the person most like himself.

Together with Dr. J. Mason Hundley, Jr., Grant organized the tumor clinic at the University of Maryland Medical School and subsequently he organized and headed the Surgical Tumor Clinic at Hopkins. He devoted large blocks of time to teaching, research and patient care in these two institutions, as well as others. Throughout his professional career, he always had a great deal of interest in teaching students and house officers and in assisting the latter with unusual operations. The house staff loved and admired him, as did his associates, nurses and patients. He was never too hurried to lend a helpful hand and always was kind and tolerant.

Grant Ward was not a well man during the last twenty years of his life. In 1940 he had an ileostomy for chronic ulcerative colitis, in 1942 a tumor was removed from his cervical spinal cord and he was left with a partial, but grave, paralysis of his right arm, and he had repeated bouts of thrombophlebitis. The ileostomy bag, the right arm-body harness (which would have taxed a gladiator) and the rubber stockings would have caused most people to call it quits, but not Grant. He further educated his left hand and re-educated his right and continued as though nothing had happened. One day, at the end of an eight hour operation, he was asked how he stood it and if he were not tired and he replied simply, "I do not allow myself to think about it." He was a living example of the fact that courage is a major virtue and that all things work together for good to one who is unafraid.

Despite his many handicaps Grant led a most productive and useful life. He published two books and approximately one hundred scientific papers, many of which dealt with cancer. He was quite active in medical and civic affairs. On two occasions he was vice-president of his State medical society and in 1956 he was president of the Baltimore City Medical Society. He was president and chairman of the Board of Directors of the Maryland Division of the American Cancer Society for many years. Honors include an honorary degree from Baldwin-Wallace, honorary membership in Alpha Omega Alpha, citation as "Man of the Year" by Goodwill Industries, and a special citation by the Baltimore City Medical Society for inspiring service. Throughout his adult life, he was active in the affairs of his church with particular interest in the mission fields, at home and abroad. He was led by his Christian faith and he understood the importance of the spiritual as well as the physical well-being of his patients. His happy home life undoubtedly helped him greatly in conquering many adversities.

It seems fitting to conclude these remarks about the most courageous and one of the most capable physicians I have known with the following editorial from *The Evening Sun* on Monday, February 17:

> "Not always does a man who achieves eminence in his profession also reach quite the same greatness of spirit and character. Dr. Grant E. Ward did. His brilliance as a surgeon was a two-fold gift. He gave life to many for whom there would have been little hope in less skilled hands. And he inspired and taught thousands of his colleagues who have been better doctors for having learned from him.
>
> "Coupled with his professional skill was a compassionate heart and a great courage that carried him through crises which would have defeated a lesser man. The operation which left him with a crippled right hand midpoint in his career served only as a spur. He devised a harness of steel and leather to perform the function of his useless muscles. He developed additional dexterity with his left hand.
>
> "Faith was, perhaps, the great cement which bound these qualities of spirit and ability together and Dr. Ward freely acknowledged his faith. His death at 61 is premature. But what man would wish to accomplish more in that span of years."

The Johns Hopkins Hospital
Baltimore 5, Maryland

Scientific Papers

CARCINOMA OF THE HEAD AND NECK*

SYMPOSIUM

MODERATOR: GRANT E. WARD, M.D.
SUBSTITUTE MODERATOR: ROBERT G. CHAMBERS, M.D.
PANEL MEMBERS: MURRAY M. COPELAND, M.D.
FERNANDO G. BLOEDORN, M.D.

INTRODUCTION

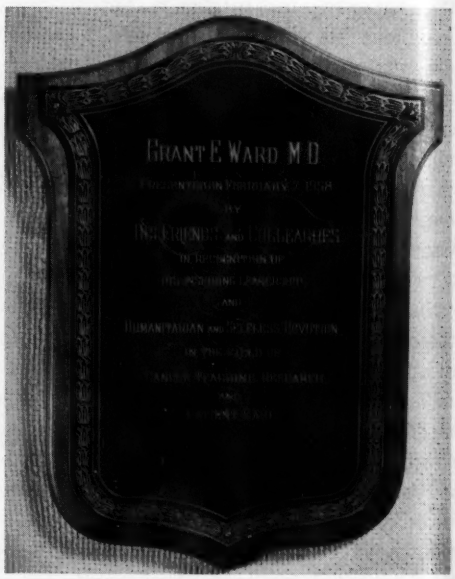
DR. WHITMER B. FIROR, President, Baltimore City Medical Society: At this time, I take pleasure in asking Dr. Louis E. Goodman to step forward.

DR. GOODMAN: Tonight's meeting has been arranged and prepared as a testimonial to one of the finest practitioners of the art of medicine, one with whom it has been an honor to be associated. I refer to Grant Ward. Dr. Ward had been announced as the Moderator for this evening. Unfortunately, he is ill and will not be here tonight. Many of his friends, associates and former associates have felt that they wish to express, in some tangible form, their deep admiration for a wonderful physician, friend and man.

With this in mind, we of the Cancer Section of the Baltimore City Medical Society and his friends and associates, are presenting, tonight, a plaque which will be hung in the halls of the Medical Society as a token of our esteem. The plaque reads as follows:

"Grant E. Ward, M.D.—Presented February 7, 1958 by his friends and colleagues in recognition of his inspiring leadership and humanitarian and selfless devotion in the field of Cancer Teaching, Research and Patient Care."

Dr. Firor, may I present this to you on behalf of his friends and colleagues.



DR. FIROR: Thank you very much. I accept this plaque on behalf of the Baltimore City Medical Society and shall request the Medical and Chirurgical Faculty to provide suitable space for it.

Some of the out-of-town guests who are here for this occasion are: Dr. G. B. Mider, of the National Cancer Institute in Bethesda; Dr. John M. Blockson, III, of Salisbury, Maryland; Dr. John O. Robben, of Silver Spring, and Dr. F. S. Hofmeister, of Buffalo, New York.

We are all very distressed because Dr. Ward cannot be with us as the Moderator tonight. His able associate, Dr. Robert G. Chambers, will substitute for him.

* Presented before the members of the Baltimore City Medical Society, on Friday, February 7, 1958, at the Medica, and Chirurgical Faculty Building, 1211 Cathedral Strleet Baltimore 1, Maryland.

DR. CHAMBERS: Cancer of the head and neck has been a field of extreme interest to Dr. Ward and to me. I am going to read the paper that Dr. Ward planned to present tonight.

Cancer of the Head and Neck comprises about 17 per cent of all human cancer. About 35 years ago most cancers of the oral cavity were treated by irradiation except small cancers of the tongue. Lip cancer was treated by both irradiation and surgery. Malignant lesions of the tonsils, pharynx and base of tongue were largely referred to the radiologist. As time went on the limitations and complications of irradiation therapy became evident. At the same time improvements in irradiation techniques and the development of such new modalities as Cobalt-60, radioactive gold grains, etc. have added much to the armamentaria of the radiologist.

During the past 15 years, advances in surgery have increased the number and extent of operative procedures in this area and greatly reduced the operative mortality. Better anesthetic agents, intratracheal administration of anesthesia and blood from a blood bank are making possible long and tedious operations with little shock and respiratory complications. Patients can now undergo operations of 6–8 hours duration with shock so well combatted that they may be out of bed in the next day or two. Antibiotics have taken away the dreaded danger of pneumonia and postoperative infections in the neck when both mouth and neck are in the same operative field. Frequent use of tracheotomy has lessened sudden postoperative deaths from aspiration of mucus and blood.

Improvements in plastic and reconstructive surgery and the use of newer and more efficient prostheses are contributing to earlier and better rehabilitation of the patients with their return to active, happy social and economic life. Reparative procedures may be immediate at the time the cancer is removed or delayed until a later date depending on the circumstances in each case.

All of these factors have improved the outlook for patients with cancer of the head and neck. Tonight our two panelists, Dr. Murray M. Copeland, Professor of Oncology, Georgetown University, Washington, D.C., and Dr. Fernando Bloedorn, Associate Professor of Radiology and Chief of Radiotherapy Division of the University of Maryland, both have been trained as surgeons and radiologists. They, therefore, should furnish valuable information on the various methods of treating head and neck cancer and be able to answer questions from the audience. They can also tell us when and in what manner surgery and irradiation should be combined in the treatment of patients with cancer of the head and neck.

Etiology: Chronic trauma is considered a very important etiological factor in cancer of the oral cavity. Ill fitting dentures, ragged unkept teeth, constant infection in the unhygienic mouth are certainly contributing factors. Tobacco and alcohol are added irritants, and these probably play an important etiological role in not only cancer of the mouth, but in the oropharynx and the hypopharynx.

Weather—wind and sun and storm—contribute much to the development of cancer of the lips.

Symptoms: Actually, cancer of the head and neck should be diagnosed earlier than any other type of cancer except cancer of the skin. However, in spite of the attempted education of the medical profession and laity, many cases of cancer of the lip, mouth and pharynx come in late stages. There are certain silent areas such as the hypopharynx and base of the tongue and even tonsils, where malignant tumors may grow to large size before producing local symptoms.

On the lip, the first symptom is usually a small scaly area, a wart, or a fissure that does not heal under local treatment. Slight induration beneath any of these benign areas is very suspicious of invasion and neoplasm.

Tonsils and Pharynx: These are more or less silent areas. Oft times the patient will state that he "didn't notice anything wrong with his throat until a few weeks or a month ago." On examination a 3 or 4 cm. vegetative growth may be found which certainly took longer than three or four weeks to grow. However, the most com-

mon symptom for carcinoma of the tonsil is sore throat.

Pharynx: In the nasopharynx the symptoms of nasopharyngeal carcinoma may be nasal obstruction, discharge, unilateral deafness and pain. The nasopharynx is rather insensitive so that pain is usually not an early symptom. An important first symptom is appearance of a lump in the neck. Any painless lump in the neck not associated with an acute inflammatory disease in the head and neck should be looked upon with suspicion of metastasis from some place in the nasopharynx, pharynx, hypopharynx, larynx, or mouth until proven otherwise. Often patients come in with a history of having been treated with antibiotics for an indefinite period without any recession in the lump. As a matter of fact, it has grown in spite of the treatment. On careful questioning, they often state that no examination of the mouth or pharynx was ever made.

The prevalence of the first symptom of nasopharyngeal tumors will depend upon the specialist who sees the patient first. The surgeon sees those cases with lumps in the neck; the otolaryngologist, those with nasal obstruction, discharge, epistaxis, or unilateral deafness; the ophthalmologist sees the patient with double vision before anyone else.

Although this panel does not intend to take up a discussion of carcinoma of the larynx, yet a word about differentiation in the symptomatology between the early cases of carcinoma of the larynx and the hypopharynx is important. Most early cases of cancer of the intrinsic larynx will begin with hoarseness, whereas most cases with hypopharyngeal cancer will have a first complaint of sore throat. Even though a patient with cancer of the larynx may come in with a sore throat and a patient with cancer of the hypopharynx with hoarseness, careful history taking will help in differentiating the primary site.

Salivary tissue tumors are often confusing. In the parotid area, the most common first symptom is a painless lump. The more benign tumors, such as mixed cell tumors, may have a history of many years duration with slow growth and no pain. There may be sudden increase in size of the growth which would signify that malignant change has taken place, and one should be suspicious of carcinoma or sarcoma.

Pain in the tumor is very suggestive of cancer. In the later stages, facial paralysis is suggestive of cancer. Rarely, a malignant tumor may arise deep in the parotid and produce pain and facial paralysis without visible swelling or palpable lump. It is rare and almost unheard of to note facial paralysis or pain in a benign salivary tissue tumor of the parotid.

A careful examination of the parotid area is not complete without looking in the pharynx, and palpating both lateral pharyngeal walls for comparison. Not uncommonly, a salivary tissue tumor begins deep in the parotid, medial to the mandible, and may present in the pharynx.

Tumors in the submaxillary gland are usually painless. When they vary in size, one should be suspicious of a stone in the duct or gland itself. Malignant tumors are seen here, as well as in the parotid gland. It is interesting to note that the percentage of malignant tumors of the salivary tissue increases the farther away the tumor is from the parotid area. For example, in the series of cases we studied in 1949, it was found that 22 per cent of all tumors in the parotid gland were malignant, 25 per cent of all tumors in the submaxillary gland were malignant, and 33⅓ per cent of all aberrant salivary tissue tumors were malignant.

The significance of a lump in the neck: As mentioned above, there are certain areas in the nasopharynx, pharynx, larynx, and mouth which are silent, and malignant disease may get quite a head start in these areas before any local symptoms occur. Often the first symptom is a painless lump in the neck. Physical examination of the mouth and the oropharynx often reveals whether this lump is of an inflammatory character by ruling out a primary sore throat or cold. If there is any question of ulceration or lump in the oropharynx, then the patient should be referred to a specialist in the nose and throat field for thorough examination. Any lump in the neck of more than a week's duration requires a careful nose and throat examination to rule out a primary focus. This can be done without discom-

fort to the patient and without hospitalization, and is as important as the stethoscope in the diagnosis of cardiac or lung pathology. When a primary focus is not found, a biopsy of the lymph node should be made. This can be done under local anesthetic on an outpatient basis.

There is no excuse for inadequate diagnosis. A biopsy should be done by a surgeon experienced in neck surgery because an ill-placed biopsy scar might interfere with proper surgery or radiation therapy later on. The average surgeon tends to make a tiny, imperceptible scar for cosmetic reasons. For example, a small scar in the submaxillary region is usually placed high up under the jaw. If a radical neck dissection has to be done later, this primary scar can be excised only with difficulty and with more mutilation when the major surgery is performed. Instead of placing the scar high up under the jaw, it should be placed down about the level of the hyoid bone and the upper skin flap lifted up to obtain the nodule. Then, if subsequent surgery is needed, the new incision can be so placed as to take in the original biopsy incision and all the original operative field, and still have a big enough skin flap to turn down and tuck nicely under the jaw. Likewise, a biopsy of a node along the sternomastoid muscle should be done through an incision along the anterior border of this muscle so that the scar and area of the operation would be included in the subsequent major surgery.

Diagnosis: Clinical diagnosis of cancer of the lips or oral cavity is usually made on inspection and palpation. The lip lesions are usually button-like, or maybe cauliflower, or warty, but the induration is a significant characteristic of malignancy. Lesions in the mouth may be infiltrative and ulcerated, or they may be cauliflower and vegetative, but the induration is the important fact. Every lesion in the oral cavity and the hypopharynx should be palpated, the finger being covered with a glove or finger cot. This is as important as palpating the abdomen when making a diagnosis in a patient with abdominal complaints. Infiltrative areas that cannot be seen are often picked up.

Biopsy: Biopsy is an exceedingly important step. No definitive diagnosis of cancer should be made without it. Even if the pathologist reports that the tissue shows chronic inflammation, if there is any clinical suspicion of cancer and any induration, further biopsy should be carried out. In the mouth, chronic inflammation often overshadows malignancy. It has been our experience that two or three or four biopsies sometimes are necessary to make an accurate diagnosis. After all, the pathologist can only diagnose the tissue the clinician sends to him. Do not biopsy in the sloughing area. Tissue should always be taken from the border of the lesion where one can compare normal and abnormal tissue, and their reaction to one another. When biopsy of the primary site is inconclusive and a node is palpable, it should be removed for diagnosis.

If there is any question about a salivary tissue tumor, it should be biopsied under local anesthesia and a definitive diagnosis made. Biopsy incisions can then be excised with the primary lesion without danger of subsequent seeding.

Serological test for syphilis is very important. It should not be forgotten that syphilis and cancer frequently occur together, and a biopsy should not be omitted because the S.T.S. is positive. Both are essential for accurate and complete diagnosis.

DR. FIROR: Will the participants of the Panel come forward? I am especially happy to be able to introduce an old friend and classmate, a member of the Class of 1927 at Johns Hopkins, (most of the members agree that it was the best class that ever graduated from Hopkins). Among the luminaries of that year is our next speaker; internist, pathologist, radiation therapist, oncologist; Commanding Officer of the 142nd General Hospital in the Southwest Pacific, now Professor of Oncology, Georgetown University Medical Center, Washington, D. C.—Dr. Murray M. Copeland.

MURRAY M. COPELAND, M.D.*

Mr. President, Mr. Secretary, and friends of the Baltimore Medical Society. I should really

* Professor of Oncology, Georgetown University Medical Center, Washington, D. C.

say, "Fellow-members" because I still retain an associate membership in this Society so that I may keep abreast of its accomplishments. I feel particularly honored tonight to be with you because these are hallowed halls to me and represent great traditions. I am sure they are stimulating to every physician in this community. The spirit of our old teacher and friend, Dr. J. M. T. Finney, is reflected from the excellent bust of him here on my left. I will never forget him.

I should like, if Mr. President will permit, to stop a moment and pay tribute to Dr. Grant Ward, who is extremely ill. I have known him for many years as friend, colleague and adviser. A man of indomitable will and courage; friend of students and residents and a champion of the thesis that cancer can be conquered. His light shall ever shine and his spirit pervade the corridors of our hearts and minds and guide us on to fight for victory in conquering this dread disease.

Successful treatment of cancer about the head and neck requires adequate information concerning the natural biological history of the disease. Given the site of the primary lesion, such knowledge includes the variations in cell morphology—rapidity of growth, predictable spread to regional lymph nodes or contiguous tissues and incidence of extension by the hematogenous route.

The selection of a therapeutic approach is dictated by the status of the individual tumor and the result to be expected from the chosen treatment. Extensive use has been made of both surgery and irradiation and I am not here to defend either. I am familiar with both. Dr. Bloedorn knows that there may be occasions when we might disagree tonight, but I think that both modalities of treatment have a real place in the treatment of this disease.

Successful ablation of regional lymph node extension has been accomplished largely through radical excision of the affected nodes. I think we all have to agree to that.

The majority of primary tumors in the regions of the head and neck are accessible and should lend themselves to early diagnosis and treatment. In spite of such potentially favorable factors, much is left to be desired in the control of cancer in these locations. Treatment of the primary disease has become highly effective although recurrence in the original site is still of great importance.

The primary cancer does not account for the death of the patient in the majority of instances. Mortality rates are greatly influenced by uncontrolled regional or cervical node metastases and by the incidence of hematogenous spread of the disease. This phase of the problem is of paramount concern in evaluating our present concept of therapy and in reappraising the surgical or radiotherapeutic approach to the problem.

In terms of conserving time and permitting my colleague to speak from his position, I should like to refer to some tables and make a few essential points. Perhaps during the later discussion we may bring out the finer nuances etc., which you would want to hear.

TABLE I

Cancer of the Mucous Membranes, Oral Cavity—Five Year Cure Rate

Site of Lesion	Royal Cancer Hospital, London*	Westminster Hospital, London†	Memorial Hospital, N. Y. (Martin, 1948)‡	Georgetown University Hospital, D. C.§
	%	%	%	%
Lip	66	50	70	52
Tongue	18	23	30	15
Floor of mouth	25	42	20	25
Mucosa of cheek	17	61	24	10
Gingiva	27	16	32	25
Palate	16¶	29¶	30	10
Tonsil	19	24	20	20

*Chief method of treatment, teleradium therapy—net survival figures. (After Harmer and Ledlie, British J. Cancer **4:** 6, 1950).

† Radiotherapy for primary site; surgery employed in neck. (After Harmer and Ledlie, British J. Cancer **4:** 6, 1950).

‡ Either radiotherapy and/or radical surgical procedures employed: (all comers, early and late).

§ Either radiotherapy and/or radical surgical procedures employed: (net survival). Series includes cases of Drs. Geschickter and Copeland; also case records collected by Dr. Geschickter on file in the Pathologic Laboratory.

¶ These figures adjusted to include combined percentage rate of hard and soft palate.

The primary lesion may be successfully treated either by irradiation or surgery, or both. Our concern in treating the involved lymph nodes is how best to handle them. It is interesting to view here (Table I) a selection of tumor cases from four hospitals well known to us all, each of which has a modality of treatment for this disease differing from the others in some respects.

At the Royal Cancer Hospital in London, the chief method of treatment, as late as 1950, was the use of teleradium therapy. The lip cancer survival rate is high in relation to the rest of the oral cancers, though actually they haven't done too badly in controlling cancer of the tongue. In this country, in some of our large clinics, this figure compares very favorably.

I recently talked with Dr. Danely Slaughter, of the University of Illinois, who indicated that their survival rate figures for cancer of the tongue was about 10 per cent.

At the Veterans Hospital in the Bronx, New York, where they see many late tongue cancers, the survival rate is 4.6 per cent.

The Royal Cancer Hospital has a rather respectable five-year survival rate by irradiation alone, as a modality of treatment for all intra-oral cancers.

At the Westminister Hospital in London as late as 1950, they were using irradiation for the primary site and surgery was employed in the neck—meaning that indicated radical neck dissection was being done as a procedure in discontinuity—the primary having been controlled. And here we find the figures are, in general, comparable.

Of interest is cancer of the mucosa of the floor of the mouth and cheek. The survival rates are 42 per cent and 61 per cent, respectively, by irradiation techniques for the primary lesion with neck dissection in discontinuity when indicated. On the other hand the survival rates from other sites are less encouraging.

The Memorial Hospital statistics, as late as 1948, represent survival rates from either radiotherapy and/or radical surgical procedures. In about 1942, radical surgery became the treatment of choice. Prior to that time, irradiation excelled in the treatment of cancer. I think that irradiation has a place in the treatment of oral cancer despite the current attitude at Memorial Hospital. We note the figures from Memorial Hospital, which are not greatly different from those where radiation, and/or radiation and surgery have been used. A combination of both treatments were used during this period reported.

Our figures represent Dr. Bloodgood's material, plus our own experience. We have had many late cases in our patient load. Our figures reflect a lower survival rate because of this factor. A more recent series of patients studied by us indicate a much higher survival rate.

There is much left to be desired in the over-all picture of absolute survival rates in cancer largely, I think, because we are seeing too many cases late in the disease before treatment is instituted.

Now, let us assume that we have the ideal approach to this disease. We must remember in general that symptoms appear time wise in relation to the position of the lesion in the oral cavity. The nearer the tumor is to the anterior portion of the mouth, the earlier the symptoms. The further we go back into the oral cavity, to the oro-pharynx and beyond, the later symptoms may appear. Delayed diagnosis, therefore, often occurs, which is unfortunate. Assuming that we may have lesions not more than 2 cm. in diameter about the oral cavity and diagnosed early, we presently may have a five-year survival rate up to 60 per cent as compared with the over-all, all-comer figure of 37 per cent five-year survival rate, which reflects a poor prognosis. Let us hope that through our dental profession, our internists, our surgeons and anybody who sees a patient, the routine checkup will bring such lesions to us early; that we won't treat them with silver nitrate sticks, gargles and antibiotics but that we will take the trouble to do a biopsy or have a biopsy done to prove the case. Cancer of the mouth comprises about 4 per cent of all human cancer, and 7 per cent of all cancer if the upper respiratory and alimentary tracts are included.

If we do not have lymph nodes involved, the outlook is better. The percentage of patients

TABLE II

Five Year Survival Rates in Neck Dissection alone, when Nodes are Positive for Carcinoma of the Head and Neck: (Combined Procedures not included)

Site of Primary Lesion	Percentage of patients with nodes involved	Percentage of 5-year Survivals
Lip	4 to 30	24 to 47.8
Tongue	35 to 68	4.6 to 21.7
Gingiva	25 to 68	25 to 26.6
Palate	25 to 40	10 to 30
Tonsil	58 to 87	12.5 to 26
Buccal mucosa	33 to 50	29.6
Floor of mouth	25	21.7
Major salivary glands	32	14.3 to 17.9
Thyroid	34.8 to 75	
Malignant melanoma	49 to 60	7 to 14

Compiled statistics from the literature, representing highest and lowest percentage rates encountered.

with lymph node involvement from lesions about the head and neck when first seen is from 4 to 87 per cent (Table II). And between 4 and 47 per cent of those patients with lymph nodes involved are living five years or more afterwards without disease. In tongue cancer, from 35 to 68 per cent of patients may have lymph nodes involved when we first see them. (The 68 per cent figure was reported from the Veterans Hospital in the Bronx.) There were 4.6 per cent survivals in that group. In palate carcinoma, 25 to 40 per cent of all patients have neck metastases when first seen. In tonsil carcinoma, 58 to 87 per cent of patients may have lymph nodes involved when first seen.

By using the newer modalities of surgical therapy, which were advocated by Hayes Martin and his group beginning in about 1942 and now generally in use over the country among surgeons, our survival figures have risen significantly. Dr. Charles Harrold, at Memorial Hospital, has reported 328 combined operations for intra-oral cancer. Forty-six per cent of these patients fell within a five-year follow-up period. Thirty-three per cent were living five years after therapy. My own recent figures indicate a 50 per cent five-year survival without disease in a small group of patients studied. I think that in the ultimate, if we can see patients early and do an adequate operation, we will have a substantial group of five-year survival figures.

The extent of the disease is important in determining the therapy to be used. As far as hematogenous metastases are concerned from lesions about the oro-pharyngeal ring, transitional cell carcinoma and lympho-epithelioma metastasize readily by the vascular route in 40 per cent, or more, of cases. Squamous cell cancer is more apt to spread by the regional lymph node route, traveling through echelons of lymph nodes. Late diagnosis usually finds several echelons of nodes involved. Ultimately the disease invades the deep jugular chain of nodes and spreads to the mediastinum and other remote areas. We may find certain cross-metastases which complicate the picture. What are we going to do to prevent the spread of the disease and if it has spread what do we do about it? Upon these answers depend the salvage rates.

The control of the primary disease may be accomplished by surgery or irradiation. Radical neck dissection in discontinuity may be elected for treatment of extension of the disease into the lymph nodes. This leaves something to be desired because we are not getting the total lymphatic spread between the controlled primary and the point of neck dissection.

Radical neck dissection in continuity with removal of the primary lesion gives more assurance of complete removal of the cancer where neck nodes are involved. When you see these individuals after unilateral combined procedures of the neck and face, the cosmetic result is agreeably satisfactory. We may have a lesion, for instance, on the alveolar ridge or in the floor of the mouth. We can do a hemimandibulectomy and remove adequate soft parts in continuity with a neck dissection. This is the ideal procedure to get beyond the disease. We can teach such patients to occlude properly, to use the residual neck and face muscles properly and they are very happy individuals. Plastic replacement surgery may further enhance the good postoperative result.

If a tumor has grown up along the tonsillar fossa and into the palate region one can do a

radical excision in continuity with neck dissection and by appropriate plastic closure have a reasonable human being left.

We can do less radical procedures and beg the question to an extent. So, advisedly, I point out some of the less radical procedures we may do for treatment of cancer. Such procedures include the pull-through operation. Dr. Ward introduced this procedure years ago. He is outstanding in introducing certain progressive operative procedures about the head and neck. He originally introduced his pull-through operation as bringing the dissected tissue out through the mouth. Others have brought the freed tongue and tissue down below the mandible for resection. The point is to be sure that you get the total disease. The neck dissection can be done in continuity when using the pull-through procedure. The advantage, if there is any, is that one has a remaining alveolar ridge, which cosmetically is desirable. If there is any question in your mind about getting around the total disease, you should do a wide ablation of the local area with a portion of the mandible, if necessary, and neck dissection in continuity.

For lesions along the posterior tongue, or back toward the base of the tongue, one can do the neck dissection, transect the mandible posteriorly and by certain maneuvers get a very good view of the posterior pharyngeal area and do an adequate resection. One may fail to control the disease if there is inadequate removal of tissue.

For floor of the mouth lesions of limited extent we may resect the inner table of the mandible with wide excision of the tumor and do a supraomohyoid neck dissection in continuity, leaving the outer portion of the mandible for stabilization and cosmetic reasons. This procedure should not be used if there is any doubt as to the extent of disease.

What are some of the complications that we may have in doing these radical procedures? Certainly post-operative shock would be one. Many of our patients have passed the ages of 50 or 60; some of them are approaching 70, a few 80, years of age. I think medical evaluation of these patients with the use of digitalization and appropriate diuresis will prevent post-operative difficulty in many older people and shock should be minimized with proper replacement of fluids, etc.

We may injure the cervical pleura. We may have cerebral sequelae from ligation of the common or internal carotid artery. We may have mediastinal emphysema and thoracic duct injury which can be quite disturbing for a period of time. We may have partial tongue paralysis on transection of the twelfth nerve. I have resected the vagus nerve now in about 10 cases on one side or the other with little or no abnormal change except hoarseness. Temporary dysphagia, wound infection and occasionally Horner's syndrome are also complications.

Due care and vigilance will prevent unnecessary occurrence of all these complications in a majority of cases. The extent of the cancer in some patients warrants the deliberate removal or disruption of certain of these vital structures.

There is a real place in cancer about the oral cavity for using radiotherapy and, particularly in the hands of the enlightened radiotherapist of today, using cobalt and other modalities of irradiation.

Mr. President, I would like to turn the meeting back to you and look forward to hearing Dr. Bloedorn. Thank you.

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DR. FIROR: The medical community of Baltimore has been very fortunate in obtaining the services of our next speaker. He came to Baltimore from the Anderson Hospital and Tumor Institute in Houston, Texas, and was the envy of radiologists, I am sure, when he obtained radioactive cobalt. I take pleasure in introducing the Associate Professor of Radiology and Head of the Division of Radiotherapy at the University of Maryland School of Medicine—Dr. Fernando G. Bloedorn.

FERNANDO G. BLOEDORN, M.D.*

Thank you, Dr. Firor, members and guests. I shall present the point of view of radiotherapy

* Associate Professor of Radiology and Head of the Division of Radiotherapy, The University of Maryland School of Medicine.

in the treatment of some tumors of the head and neck.

The surgical treatment of carcinoma of the head and neck is the best known and the most widely applied. It is an undeniable fact that surgery has made great progress in the last fifteen years and, due to its progress, the cure-rate—along with the hope of many patients affected with head and neck malignancy—has improved considerably. In spite of the trauma and mutilation imposed upon the patient in some cases, it is indeed the treatment of choice and a life-saving procedure. If it is agreed that the ideal cure of carcinoma should be that which sterilizes the growth and yet will not destroy normal tissue or function, we have to realize that surgery should be considered as a treatment of necessity.

Radiotherapy is also a local means of tumor destruction and is more specific in its action, providing the proper indication and techniques are used. It is true that in many cases permanent changes are produced in normal tissues exposed to the beam of irradiation, but in most instances these changes are compatible with their life and function. Although it is not the ideal treatment for carcinoma, it represents one step forward toward the desired aim.

Radiotherapy has also made great progress in the last two decades in improving techniques, reducing the complications and increasing the cure-rates with considerably less suffering for the patient. The treatment of tumors of the head and neck is one field where radiotherapy has made the most important advances. The fact that these improvements are less known than the surgical advancements is due to several factors:

1. Radiotherapists with adequate knowledge, training and experience, are far less numerous than surgeons with equal attainments.

2. Modern equipment for a good radiotherapeutic service is very costly and, therefore, seldom available.

3. All patients seen by a radiotherapist are referrals and, therefore, are rarely seen before some type of therapy is instituted. Because of this, many opportunities for good therapy are lost.

FIG. 1. Infiltrating squamous cell carcinoma of the tongue involving half the tongue and the right side of the floor of the mouth. Patient 72 years of age. Treatment: Radium implant, volume type, covering entire tongue and right floor of the mouth. Dose delivered: 7000 r. in 7 days. Patient treated at the M. D. Anderson Hospital, Houston, Texas. Dr. Gilbert H. Fletcher's service.

FIG. 2. Same patient 4 years later. No active disease in the mouth. The patient had lymph node metastases on the right side of the neck for which he had a neck dissection. Except for some fixation of the tongue to the floor of the mouth, the function and aspect of the tongue are normal.

The important developments that have contributed to the betterment of results in radiotherapy, especially in the head and neck, are:

1. The close association with the physicist allowing the development and calculation of new techniques of treatment, with accurate dosimetry.

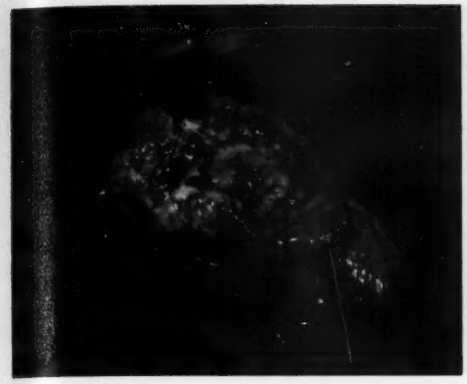


FIG. 3. Patient 40 years of age with a squamous cell carcinoma of the border of the tongue, exophytic and infiltrating. No lymph node metastasis when first seen. Treatment: Radium implant, double plane. Dose delivered 7000 r. in 5 days.

FIG. 4. Same patient 5 years later. No evidence of disease in the mouth or neck. A neck dissection was performed 3 years ago for lymph node metastases. The aspect and function of the tongue are normal. Patient treated at the M. D. Anderson Hospital, Houston, Texas. Dr. Gilbert H. Fletcher's service.

2. The development of a *system of radium distribution* and accurate dosimetry for interstitial radium therapy (Paterson-Parker system).

3. The use of *supervoltage therapy*.

4. The improvement in patient care: the control of blood, electrolytes, protein and vitamin level; the use of antibiotics and corticosteroids, etc.

5. The increased use of combined treatments: preoperative radiotherapy and radical surgery.

It is very unfortunate indeed that, from the beginning of the specialty, radiotherapy has grown in competition with surgery. At present the results to be obtained by either procedure can be predicted with reasonable accuracy in most head and neck localizations. Ideally, they should complement each other, and the treatment which offers the best chance of cure should be applied. This statement is particularly true for early and moderately advanced diseases. However, in cases where the disease is advanced, either in the primary or in the neck metastases, the results achieved thus far are discouragingly low if surgery or radiotherapy is used alone. I

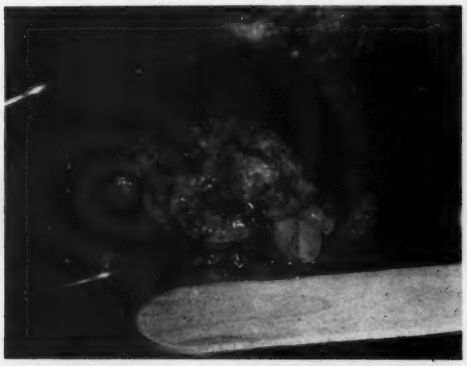


FIG. 5. Patient 55 years of age, luetic with very advanced squamous cell carcinoma of the tongue, invading the whole floor of the mouth and part of the lower gum. Neck metastasis in the right carotid chain. Treatment: Radium implant, extensive volume from the mouth and submental region. Dose delivered: 7000 r. in 5 days. Neck dissection. Patient treated at the M. D. Anderson Hospital, Houston, Texas. Dr. Gilbert H. Fletcher's service.

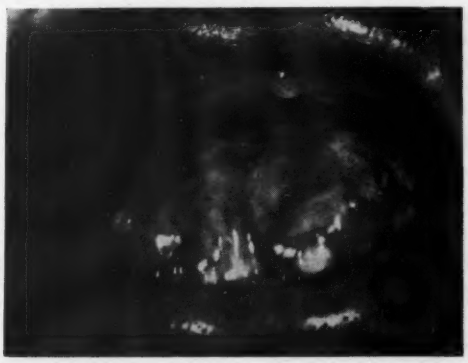
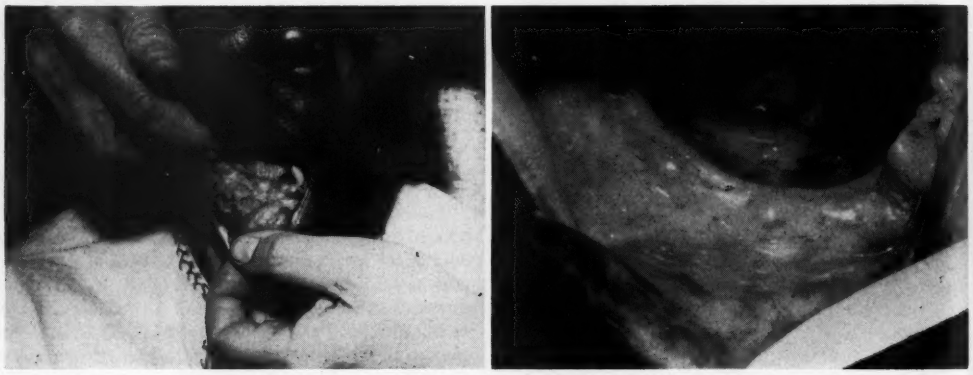


FIG. 6. View of the tongue 3 months after the completion of treatment. This patient expired 1 year after the treatment with uncontrolled neck and lung metastases. No disease at the time of death was found in the mouth.

FIGS. 7 & 8: Young patient with extensive squamous cell carcinoma of the lower gum invading the floor of the mouth, lower gum, and faucial pillar and buccal mucosa with very extensive destruction of the horizontal ramus of the mandible. Three nodes were clinically involved in the left side of the neck. Patient treated at the University Hospital, Baltimore, Maryland, with Cobalt teletherapy. The treatment area covered the primary lesion and the neck. A resection of the left jaw was performed 4 months after therapy. The specimen and several biopsies taken at the operation were free of tumor. Patient is free of disease 1½ years after treatment.



FIGS. 9 & 10: Patient 80 years of age with a well-differentiated squamous cell carcinoma of the lower gum and gingivo-labial sulcus with fixation and invasion of the bone. One submaxillary node was clinically metastatic. Treatment: The patient was treated at the University Hospital, Baltimore, Maryland, with Cobalt-60 teletherapy. The area irradiated was the site of the primary lesion and also the submaxillary region. The treatment was well tolerated with a minimum of reaction. Patient is free of disease 15 months after the completion of therapy.

believe this is the group of patients which could benefit most from intelligent cooperation between surgeons and radiotherapists. The use of preoperative irradiation, supervoltage whenever possible, and a radical operation is the only way offering better hope for the future.

This should not be a haphazard combination of procedures. A whole system should be developed by a well-organized team (surgeon and radiotherapist). Both procedures of therapy should be applied following different principles of techniques. The period of rest between treatments should be established in order to attain the most benefit from the previous irradiation.

The examples shown are all of extensive squamous cell carcinoma of the head and neck treated by irradiation alone or by a combined treatment of irradiation and surgery.

SUMMARY

The most important indications for different types of radiotherapy used alone and in different combinations with surgery could be summarized as follows:

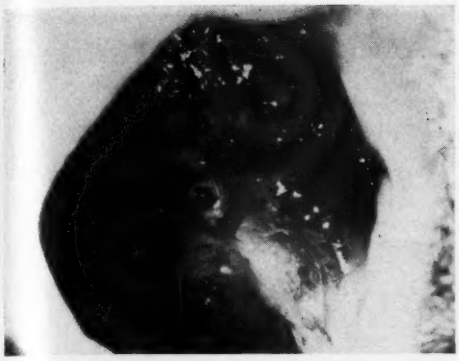


FIG. 11. Patient 74 years of age with an extensive squamous cell carcinoma of the soft palate and anterior faucial pillar. The lesion is highly infiltrative. No nodes are palpable in the neck. Treatment: Cobalt teletherapy at the University Hospital, Baltimore, Maryland, which was well tolerated with a brisk reaction of the mucosa of the treated area. There was only mild erythema of the skin.

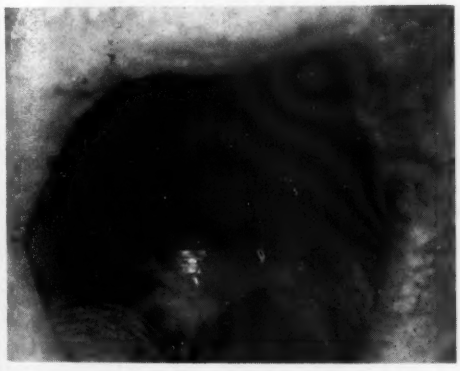


FIG. 12. Same patient one year after the completion of treatment. He is alive and free of disease.

I. Radiotherapy alone:
   1. Lip (medium to large tumors): X-ray or radium
   2. Oral cavity (squamous cell): Radium or Cobalt-60
   3. Oropharynx: X-ray or *Cobalt-60*
   4. Pharyngeal wall: X-ray or *Cobalt-60*
   5. Nasopharynx: X-ray or Cobalt-60
   6. Cervical eosphagus: X-ray or *Cobalt-60*

II. Primary with radiotherapy, nodes with surgery:
   1. Lip.
   2. Oral cavity (squamous cell).
   3. Paranasal sinuses (squamous cell).
   4. Middle ear.

FIG. 13. Patient 62 years of age with destructive squamous cell carcinoma of the soft palate with invasion of the anterior pillar and base of the tongue. No nodes. Treatment: Telecobalt therapy at the University Hospital, Baltimore, Maryland. Good tolerance. Mucositis of the treated area and only mild erythema of the skin.

FIG. 14. The same treated area 8 months after the completion of treatment. The punched-out hole is the result of tumor destruction.

FIG. 15. Aspect of the skin 8 months after treatment. Minimum radiation changes.

FIG. 16. Patient 52 years of age with recurrent or residual squamous cell carcinoma infiltrating the entire left side of the neck. The primary tumor was in the left side of the tongue and was resected 6 months prior to this view. The patient underwent a radical neck dissection and partial resection of the jaw 3 months before this picture was taken for a large node metastasis attached to the carotid. Treatment: Cobalt-60 teletherapy and extensive radium implant at the University Hospital, Baltimore, Maryland.

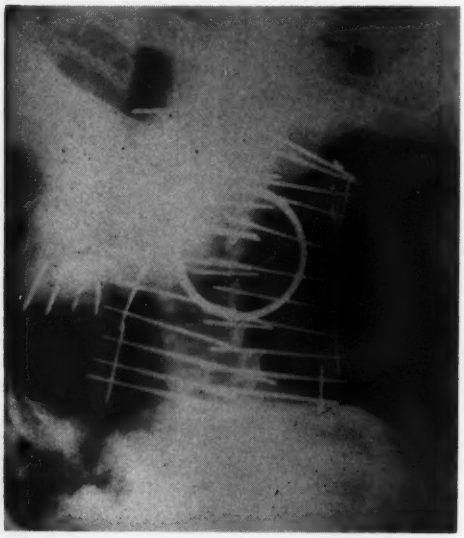


FIG. 17. View of the radium implant which covered the entire left side of the neck and submaxillary area.

III. Radiotherapy plus surgery:
   1. Paranasal sinuses: X-ray, *Cobalt-60* or Radium
   2. Extensive gums and hard palate, (squamous cell with large bone invasion): X-ray or *Cobalt-60*
   3. Advanced neck metastasis: X-ray or *Cobalt-60*

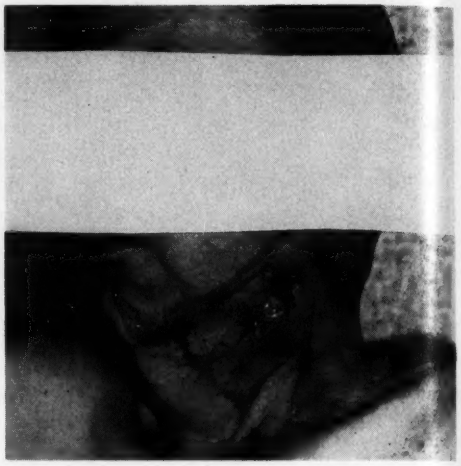


FIG. 18. One year later the disease in the neck is controlled. One year later the patient developed neck metastases in the right side which were treated for palliation with Cobalt-60 irradiation. Presently, the patient has a metastatic node in the right side of the neck which is uncontrolled. The left side of the neck is free of disease.

   4. Middle ear: X-ray or *Cobalt-60*

   Oral cavity recurrent tumors (after radiotherapy): Radium or Cobalt-60

IV. Surgery plus radiotherapy:
   1. Malignant salivary gland tumors: *Radium* or *Cobalt-60*
   2. Recurrent neck metastasis (after surgery): *Radium* or *Cobalt-60*

   All recurrent tumors (after surgery): X-ray, *Cobalt-60* or *Radium*

Italics indicate therapy of choice with definite advantages.

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DISCUSSION

DR. CHAMBERS: This is a rare opportunity to get two such well qualified experts in their field to answer any pertinent questions. Just write your questions on a slip of paper and pass it down the aisle and we will pick them up. While we are waiting, I have a few questions. Dr. Bloedorn, it would be nice if you would mention a few complications of Cobalt-60 therapy and x-ray therapy.

DR. BLOEDORN: In our personal experience,

here in Baltimore, after one and one half years of using Cobalt-60, alone, in the treatment of many lesions of the head and neck, we have had very few complications. The girl shown with the extensive tumor of the lower gum who had 4 cms. of necrotic bone exposed by the lesion, had to have the right lower half of the jaw excised. It is a fact that due to the special quality of these rays, with the skin-sparing action and less bone absorption, the complications are avoided. We have had two hemorrhages, one fatal, during treatment of extensive tonsilar tumors, but they are not complications of the treatment, really. It is the result of the treatment melting the tumor that was already invading the carotid sheath which causes the hemorrhage. One complication which could occur several years after the treatment with the use of two parallel opposing fields or single fields when the dose is pushed to very high levels from 6000 r. or more is the one produced in the subcutaneous tissue because the maximum dose is at 6 mm. under the skin. It has been recorded in the literature.

In cases that have been treated by supervoltage therapy some ten years ago, we know of serious complications such as severe fibrosis and even necrosis, a very deep type of necrosis, sometimes affecting the jaw and the temporal maxillary joint. We are trying to prevent this type of complication by avoiding as much as possible the use of two parallel opposing fields to a very high level. Also, we have to consider that the depth dose is so much more efficient than with conventional therapy that the reaction of the mucosa is generally earlier in appearance and also is more severe but shorter lasting. In summarizing, most of the common complications from the use of conventional voltage are reduced with the proper use of supervoltage therapy. Other complications inherent of the physical characteristics of supervoltage can be prevented.

QUESTION: Do you think x-ray therapy can ever convert an inoperable lesion into an operable one?

DR. BLOEDORN: Definitely yes. The old concept that once a lesion is inoperable and that it can never be rendered operable by radiation, I believe is incorrect. Such thought was based especially on tumors of the breast. In tumors of the breast the problem is different because when the lesion is extensive locally, the patients generally have distant metastases and the treatment is doomed to failure. In tumors of the head and neck, where the lesion sometimes remains localized for several years, experience has proven that inoperable tumors can be rendered operable.

QUESTION: Do you use delayed flaps or primary closure in your commando procedures where large amounts of skin are to be sacrificed in the neck?

DR. COPELAND: Yes, I use delayed flaps on occasion. Our colleague Dr. Ward, here at Hopkins with the plastic surgeons, worked out a very fine technique. I think Dr. Chambers had something to do with it and is to be congratulated. It has a very definite place particularly in cheek lesions or in extensive ulcerating lesions where a wide dissection of skin and soft part structures is necessary.

I should like to comment on Dr. Bloedorn's remarks. He is certainly a great enthusiast for the use of cobalt therapy and apparently it can do no wrong. He sounds like Charlie Martin, of Dallas, Texas, in discussing radium. I must admit I haven't had an extensive experience with telecobalt therapy, but I have observed teleradium therapy at Memorial Hospital in the early 1930's. Such therapy has a comparable effect on tissues, and of course, in the application of radium needles and radon seeds where one utilizes interstitial radiation, we have seen much bone necrosis.

It seems to me that the reason for this necrosis is largely one of bone devitilization with superimposed infection. After treating an ulcerated tumor with considerable infection or following a good result from therapy for some reason, the healed mucous membrane is perforated, an infection is activated in devitalized bone, which we speak of as radionecrosis.

Actually, the bone which is affected by irradiation is pretty much an inert structure produced by large dosages of radiation. If the devitalized bone is not infected it acts as a graft lying there, and it is only through the complication of infection that radionecrosis supervenes.

In our experience, which does not include cobalt therapy, following treatment by the intermediate voltages of radiation, 250 KV or 140 KV, and/or the use of radon and radium needles for oral cancer, radiation bone necrosis has occurred in about 20 per cent of the patients.

I feel that with the use of antibiotics and by the judicious use of radiation, bone necrosis is being reduced as a complicating factor. We have been able to control some of our radiation necrosis locally by the use of antibiotics without having to do a resection.

I see Dr. Bloedorn wants to make a rebuttal.

DR. BLOEDORN: I enjoy making Dr. Copeland happy. In our short experience in Baltimore, we have not had necrosis, except the one case mentioned, when we used Cobalt-60 alone. We have had, however, about three or four such complications when we tried to combine Cobalt-60 with radium. I thought it would be a good idea in order to diminish the volume of tissues to be irradiated to treat from the outside with cobalt and inside with radium implants. In our experience for the control of the disease, it is a very good procedure, but after six months almost 50 per cent of the patients developed necrosis. That is about three or four patients, and I think it is due to our high dose. We are planning to control that complication by reducing the dose delivered.

Now in our experience with Fletcher, in Houston, we have had some necrosis with the use of supervoltage and especially with Cobalt-60. These were mostly in the lateral wall of the pharynx in patients treated with very high doses. It was a calculated risk in order to save some otherwise hopeless patients.

QUESTION: How often do you get a skin slough following surgery after Cobalt?

DR. BLOEDORN: Well, that will depend entirely on the technique of the surgery performed later on. As I stated, the type of surgery had to be adapted to a different modality. The incision has to be carefully planned. The flaps have to be thick, with a good blood supply, etc. So far, we are developing in our hospital this type of surgery. We have had some partial necrosis of the flap which delayed the healing. In some cases where the surgery has been performed outside of our hospital, the rate of complications have been high. This is a type of therapy only possible where the therapist and surgeon work together as a team.

DR. CHAMBERS: Well, I haven't had much experience with Cobalt therapy, but Dr. Ward and I have been very interested during the past three years in using pre-operative irradiation in as high a tumor-dose as is feasible. It has been our contention that, if the surgery is planned, it makes no difference as to what type of irradiation is given. You plan to do it on a date between three and six weeks after irradiation. You will not get in trouble because your main radiation reaction is going right along with the healing. We use that for wookie-type procedures and composites, commando and all types of radical procedures about the head and neck. I think, with the exception of one or two isolated cases, there has been no difficulty at all.

DR. BLOEDORN: This type of surgery can be done. Dr. McComb, at M. D. Anderson Hospital, has reported more than one hundred such operations. They had one or two necrotic flaps. All other cases did all right with some delay in the healing. We have tried the procedure in very advanced cases where the only thing that could be offered was some type of heroic treatment. I am convinced that this type of combined therapy is useful for advanced lesions providing the proper technique is used. Radiation and surgical approaches should be applied only in places where close cooperation is possible.

QUESTION: Has the resection of the vagus nerve caused any serious complications?

DR. COPELAND: No, it has not. I would say 7 out of 10 vagus resections were on the right side. I haven't noticed any particular change in the patients except hoarseness. There was no great change in the pulse rate or cardiac rhythm. I was quite concerned in doing the first two or three vagus resections. I am sure that we would have serious problems if we resected both of the vagus nerves.

DR. CHAMBERS: I would like to comment a

little bit on the skin flaps. I think that probably the skin flap necrosis is somewhat related to the total dose that may be given to the area and the type of irradiation, wouldn't you say so?

DR. COPELAND: We have just recently had an elderly man in whom we have not found the primary, with transitional cell epithelioma in the left submental region and in the neck nodes on the right. He went for a year and a-half following irradiation with quiescence of disease and then developed recrudescence of enlarged nodes in the right mid-cervical zone. We did a right radical neck dissection on him. He had previously received a total of 6000 to 7000 roentgens of x-ray therapy in interrupted divided dosage over an extended period of time using conventional 250 KV x-ray therapy. We lost a portion of the skin flap overlying the upper common carotid artery. No granulations were present nor could they be stimulated. With Dr. Albert Fleury we quickly set up a tube graft and successfully covered the denuded area. *Problems may occur where skin flaps have had previous heavy irradiation.*

DR. BLOEDORN: For that, whenever possible, I use supervoltage therapy because of the difference in the irradiation of the skin.

DR. CHAMBERS: Dr. Ward asked me to be sure and get you to say a few words, Dr. Copeland, on why a neck dissection should be done in the absence of clinically palpable metastases?

DR. COPELAND: Well, I guess Dr. Ward is needling me a little bit because I'm not apt to do neck dissection in the absence of palpable lymph nodes *unless we are doing the commando procedure or the combined operation.* In resecting cancer of the lip I would not do a neck dissection unless lymph nodes were palpable. I also disagree with my colleague, Dr. Bloedorn, that irradiation is the best way to treat lip cancer.

DR. BLOEDORN: I said only for the medium sized or large sized tumors of the lip should radiation be the treatment of choice in order to avoid unsightly deformities.

DR. COPELAND: All right. I would not do a neck dissection for instance on lip cancer unless we had palpable lymph nodes.

DR. CHAMBERS: How about the tongue?

DR. COPELAND: I would not ordinarily do a prophylactic neck dissection for cancer of the tongue. Let me give you some statistics on the tongue to show you what we are up against. A review of the evidence for or against prophylactic neck dissection in carcinoma of the tongue leaves us in the position of having a calculated risk either way. The incidence of cervical lymph node metastases on admission is between 35 and 60 per cent of all cases. Cancer of the anterior two-thirds of the tongue ultimately metastasized across the mid-line in 21 per cent of the cases, in one series reported. This suggests a definite chance that you may dissect the wrong side of the neck or miss residual disease on the opposite side. In a group of distinctly unilateral primary lesions, metastases first appeared contralaterally in about 10 per cent of the cases and bilateral metastases were noted in 24 per cent of the patients with cervical node involvement. Now, eliminating all duplications, it would appear that in 32 per cent of all patients with cancer of the tongue, the treatment of cervical metastases must apply to both sides of the neck if the prophylactic neck dissection is to be effective.

DR. CHAMBERS: Well, how about the 25 per cent, though, that have pathological metastasis but clinically are negative?

DR. COPELAND: In that group once the metastasis occurs, your percentage of survival is materially lower. Whether or not you find them first by prophylactic operation or after they are palpated, the statistics do not show much change in what you will have accomplished. There are those who do not agree with this point of view.

DR. CHAMBERS: I don't.

DR. COPELAND: I am sure you don't and I will say this, that if a patient is operated on without neck dissection, he should have a careful follow-up. If there is any question as to follow-up because the patient is from a neighboring State or some great distance, I would do a prophylactic neck dissection. I know Dr. Ward very

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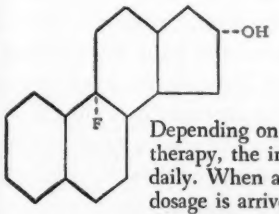

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Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about ⅓ in rheumatoid arthritis, by ⅓ in allergic rhinitis and bronchial asthma, and by ⅓ to ½ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

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definitely felt that a prophylactic neck dissection should be done in carcinoma of the tongue. Now, if we are doing a commando procedure, including the lateral tongue and hemimandibulectomy, a neck dissection is also done. I am perhaps begging the question, but that is my position.

DR. CHAMBERS: Here is a question, I think, for catch as catch can.

What is the place, if any, of chemotherapy that is; methotrexate, nitrogen mustard, aminopterin, etc?

DR. COPELAND: As far as squamous cell cancer and its variations are concerned, I don't know of any encouraging applications. Methotrexate used in treating uterine choriocarcinoma has been very effective as demonstrated at the Clinical Center of the National Institutes of Health.

DR. CHAMBERS: We have been using the various chemotherapies, sort of a last-ditch stand, and I guess we have used them in a great number of cases, but I don't think they are very beneficial unless in the undifferentiated squamous cell.

DR. COPELAND: There is one thing to be said about trying, if we do try the various modalities of chemotherapy we are doing something for the patient, and it keeps him out of the hands of less conscientious people.

DR. CHAMBERS: Well, many times that is just as important as trying to do a curative operation on him, even though the case is hopeless.

What are the advantages, Dr. Bloedorn, when there is a difference of Cobalt over conventional x-ray therapy in this group?

DR. BLOEDORN: Well, I think the principal advantage is in the treatment of extensive lesions of the head or neck. Some tumors of the oropharynx and nasopharynx can be treated by one procedure or the other. In the case of very extensive lesions due to the lack of skin reaction and to the lack of higher bone absorption, there are distinctive advantages in the use of supervoltage. Lack of skin reaction makes the patient live more happily during the treatment than with conventional therapy, especially in patients with very extensive disease where the entire neck and face have to be treated. In old patients sometimes the reaction and pain will be enough to kill the person. They do tolerate supervoltage therapy better. The lack of differential bone absorption and cartilage absorption can also be used to advantage in extensive tumor of the larynx. Also, the technique of treatment is a lot simpler.

Fletcher, from the M. D. Anderson Hospital in Houston, showed a definite improvement in the control of advanced lesions of the tonsil, base of tongue, and pharyngeal walls. In our experience the advanced lesions of the nasopharynx and laryngopharynx are also better treated by Cobalt therapy.

DR. COPELAND: We were discussing chemotherapy. Perhaps a slightly different area should be mentioned, namely, certain antibiotics such as the tetracyclenes, aureomycin and terramycin particularly. We have noticed that in oral cancer by local application of the powder, we clean up some of the infection, and have noticed some regression in size of the tumor-bearing area. There is an inhibiting mechanism about some of the tetracyclenes which is rather interesting. In extensive disease, uncontrolled by various modalities of therapy, where we have an ulcerating infected and oedematous wound, antibiotics are effective in control of pain. By carrying the patient on simple antibiotics, even penicillin alone, we find that a great many of the lesions become asymptomatic, the edema subsides and the patients are relatively comfortable although the tumor is perceptibly growing larger.

DR. CHAMBERS: I don't know whether it is you or I who is standing alone here against Dr. Bloedorn, but mostly all of these questions are addressed to him.

QUESTION: Can you discuss the complications of Cobalt with combined laryngeal surgery?

DR. BLOEDORN: Necrosis of the flap is the danger in this type of combined procedure. Unless a team is working together with previous agreement on the plan of treatment—how it should be performed, the type of irradiation to

be given and the surgery to follow—necrosis of the flap could be a common complication with production of fistulae and hemorrhage.

Any amount of infection is a very important factor in producing necrosis. The technique should be very meticulous. It should be planned previously and, especially, there should be a definite period of time between therapy and operation. Radiation is not immediate in its action. It takes two months, at least, to produce the full action of radiation to a squamous cell carcinoma.

QUESTION: Do you think the spinal cord lesions will show up as a result of irradiation fibrosis in the cord?

DR. BLOEDORN: I think so, if care to avoid them is not taken in the technique. We had some cases especially treated with Betatron in Houston. They were lesions of the posterior wall of the pharynx. The same type of lesion can be produced by the use of conventional therapy, as demonstrated by the Manchester School. However, care can be taken *in most of the cases* in order to avoid the cord in the field of the irradiation or not to go beyond its tolerance when it is irradiated.

DR. COPELAND: I would like to say something about *x-ray irradiation* ultimately producing malignant change. It happens, but it is relatively rare. Every case is reported in great detail. The most striking statistics relate some form of irradiation about the neck to the subsequent development of thyroid cancer.

DR. CHAMBERS: I have just been reminded that the time is drawing nigh. We certainly want to thank both the Panelists for a very stimulating discussion.

DR. FIROR: I want to thank the Panel for this excellent discussion. I am sorry again that Dr. Ward, the most inspiring man in the profession in the City of Baltimore, could not be here for this particular discussion.

DR. FINNEY: May I suggest, Sir, that subsequent to the meeting, we send word to Dr. Ward that we missed him and wish him well.

DR. FIROR: Thank you very much. Our Secretary will do that.

CYLINDROMATOUS SALIVARY GLAND TUMORS*

ROBERT W. BUXTON, M.D.

The accurate and effective and ultimately successful treatment of any disease, which is not in its usual course self-limited, is predicated upon knowledge of its etiology and its natural life history. While the etiology of carcinoma is not known currently, some knowledge of the natural life history of many malignant lesions is readily available; for example, much is known of the typical behavior of carcinoma of the breast, of the uterus, the colon and stomach. The life history of neoplasms of other organ tissues often are not as well recognized and some are not regularly and surely identified as malignant tumors. When this last situation obtains, much pessimism colors the treatment and prognosis and has upon occasion led physicians to pursue a course of hopeless waiting rather than one of energetic treatment.

In some respects these observations are peculiarly pertinent when related to salivary gland tumors. Those involving the parotid gland are not uncommonly given a treatment course of watchful waiting, the most obvious justification for this being the anatomical relationship between gland and facial nerve. Moreover, at least two-thirds or more of the tumors in the parotid area are the slowly growing, benign mixed tumor. Therefore, in the experience of any

* Presented at the One Hundred Fifty-ninth Annual Meeting of the Medical and Chirurgical Faculty of Maryland on Thursday, May 2, 1957, Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

one physician many tumors in this latter area behave well for a very long period of time without operative removal.

The incidence of tumors of the major salivary glands is such that few physicians have more than an occasional contact from which to gain experience and understanding. When a larger share of experience is available to be called upon, one is again faced by much confusion of histologic types of tumor and their various clinical courses. This confusion is well brought out by the mixed tumor; this is by common usage a benign lesion but some have described a malignant mixed tumor. One author suggested that because of its frequent local recurrence, one might better not treat this tumor at all, thus implying a lesion of inexorable local malignancy. Perhaps another example comes to mind in the form of the muco-epidermoid tumor. This tumor is said to exist both as a benign and as a malignant lesion. From a study of 280 tumors of the parotid salivary glands, we were unable to identify as a malignant, invasive tumor any of the muco-epidermoid tumors.

Further confusing the issue of these salivary neoplasms are a great variety of descriptive terms all used at various times to describe one lesion. The present cases are dealt with, in part, because of this unclarified state.

In 1856 Billroth described a tumor from the maxillary antrum composed of cylinders of epithelial cells surrounded by cylinders or strands of hyalinized connective tissue. Enclosed within the cylinders of epithelial cells are round or oval cavities, suggesting the appearance of Swiss cheese, frequently filled with mucin. Volkmann, in 1895, expressed the opinion that these cylindromatous tumors arose from the endothelium of blood or lymph vessels. Krompecher compared the darkly staining cells to those seen in basal carcinomas of the skin. Bauer and Fox believed that these same cells resembled myoepithelial cells and likely arose therefrom.

Thus from these and many other descriptive speculations have come the designations "cylindroma," "malignant cylindroma," "adenocystic basal cell carcinoma," "adenoid cystic carcinoma," "myoepithelioma," "adenomyoepithelioma," "adenomatoid carcinoma," "adenocarcinoma Grade I," basal cell carcinoma with hyaline stroma," "pseudo-adenomatous basal cell carcinoma," "basaloma" and many others. Upon occasions, the tumor has been designated and treated as a "cellular mixed tumor."

Tumors of the salivary glands are not common but in a large series of patients with various tumors, they form 1 to 2 per cent of the total.[1] Of 50,000 patients with tumors treated surgically, one of 208 persons was found by Stein and Geschickter[2] to have a tumor of the parotid gland and of these 17.4 per cent were considered malignant tumors. It has been estimated by various authors that from 2 to 10 per cent of parotid tumors are cylindromas.[3]

Despite the confusion of names for this group of tumors, one looks to the clinical manifestations for hope that some uniform picture may be designated as characteristic. It is a tumor seen in women more often than in men, and is reported in patients between the ages of 15 and 75 years. The tumor size may vary from 1 to 8 or more centimeters but averages 3 to 4 cms. Characteristically, the tumor grows rather slowly, as evidenced by some which have been present for 10 to 20 years. On the other hand, a few are of one year's duration only. Equally confusing, when an effort is made to contrast this tumor with a benign lesion, is the observation of many surgeons that these patients may have one to four or five recurrences, frequently with long intervals between recurrences, before distant spread of the tumor has occurred.

Still other unusual features make differentiation from the benign mixed tumor difficult. In a 20 year follow-up at the Curie Institute in Paris, Baclesse[4] found that skeletal and pulmonary metastases developed 5 to 22 years after the onset of the lesion and the initial therapy, in 7 of 11 patients whose primary lesion was uncontrolled. Despite this observation the incidence of regional node invasion is uncommon and distant spread may occur without nodal involvement.

It would thus appear that the lesion occurs in both men and women, rarely, if at all, in children.

It may be small or large. It usually grows slowly but may grow very rapidly, and while seldom involving regional lymph nodes, does so upon occasions.

Most assuredly these observations do not serve to separate clinically this malignant tumor from one which is benign for, by the time distant or regional metastases have occurred, a good prognosis can seldom be maintained.

The appearance of pain in the vicinity of or close to a salivary tumor is frequently of much significance. Perhaps 20–25 per cent of patients with the common mixed tumor have discomfort, usually upon injury, exposure to cold and occasionally spontaneously. This discomfort is well localized and aching in character. Pain from an invasive neoplasm is usually lancinating in character, persistent and usually increasing, when the individual is seen. Dockerty and Mayo[5] described persistent pain in 70 per cent of their patients with submaxillary gland cylindromas. We have reported it to occur in 60 per cent of 18 patients with cylindromas of the parotid area.[6] One of the most important histologic observations on these tumors is their invasive tendency. Capsular invasion can be observed almost regularly. There is a pronounced tencency for the tumor to appear in perineural lymphatics[8] and, in some instances, invasion of nerve bundles may be seen. In recurrent tumors, the gross appearance is often that of multiple nodules and "almost invariably within these nodules the process of nerve involvement" appears "as a sort of nucleus."[5] It is not surprising that a large number of these patients have a "carcinomatous neuritis,"[5] nor is it unusual that a fourth of them may have facial nerve palsies.[6, 9] Thus pain, particularly that which is lancinating or stabbing in character, and most particularly when accompanied by facial muscular weakness (not due to prior operation), is indicative of an invasive neoplasm and is usually commonly seen in the malignant cylindromas.

Before a planned measure of treatment is undertaken, further information must be at hand. It is a not uncommon observation that certain malignant neoplasms, when seen in the head and neck region, produce their lethal effects by invasion and destruction of structures in the head and neck region and rarely metastasize below the level of the clavicles. The malignant cylindroma is also a peculiar lesion but for quite the opposite reason. *An unusually large number*

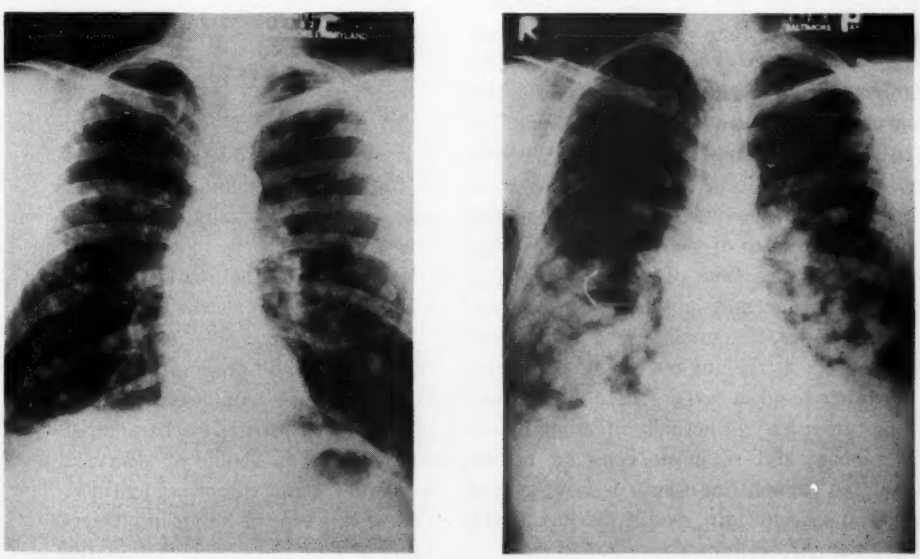

FIG. 1. Cylindromatous pulmonary metastases. Progressive dyspnea noted 3 weeks prior to taking of film on right.

of these patients develop carcinomatous pulmonary metastases. Lampe, et al. have reported a series of 25 patients with malignant cylindromas seen over a period of 19 years and of these 5 (20 per cent), were known to have pulmonary metastases. Three of their patients had lesions in the parotid gland and in one of these there was metastases to the lungs.

A further unique feature of this tumor is the fact that the clinical course may extend over a period of years even though pulmonary metastases exist. Moreover, symptomatic indication of the presence of metastases *appears late or not at all.* For example, a patient with a left parotid tumor had her first excision in 1937 and subsequent excisions in 1939, 1943 and 1945. In 1945, pulmonary metastases were first noted but no pulmonary symptoms existed. Recurrence of the primary tumor was treated in 1948. At this time the lung fields showed many bilateral metastases and still no symptoms were present. The patient, of course, subsequently did develop pulmonary symptoms and died. Nevertheless, the striking extent and sluggish growth of these metastases and the very late appearance of cough and dyspnea is a common and characteristic picture in these patients. Like the behavior of other neoplasms, not all behave in a characteristic fashion and the cylindroma is no exception; some will early declare themselves as obvious invasive neoplasms. Their metastases will be not only widespread to lungs and bone, but will be symptomatic and life expectancy will be short.

There is nothing necessarily distinctive about the gross appearance of the lesion either before operation or at the time of the operative procedure. It may or may not have an apparent capsule. Some of the small, early lesions lend themselves to a shelling-out of the nodules. On the other hand, a larger, more aggressively invading tumor may be actually invading muscle or even bone, and is, in no sense, a benign, encapsulated tumor. The tumor is firm, grayish in color and once cut into, readily distinguishable from normal parotid tumor.

Upon microscopic section, there are fields of tumor cells strikingly uniform in size and rarely showing mitoses. The cells are typically arranged about irregular spaces filled with hyaline material. The cells themselves are small, cuboidal, pink-staining with dense, regular, oval or round nuclei.

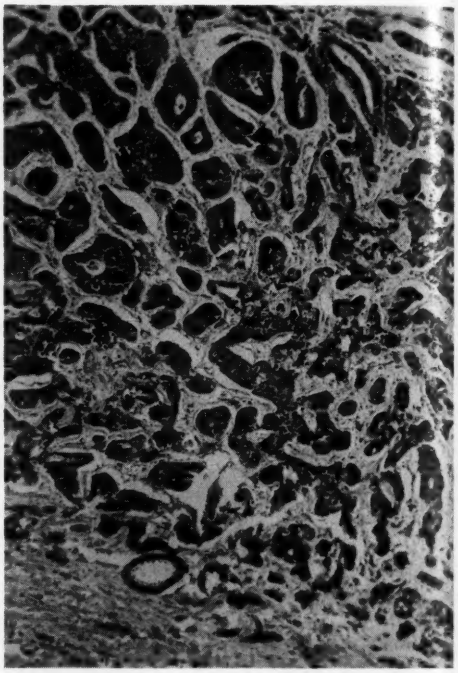

FIG. 2. Parotid gland cylindroma

Although all varieties of this tumor appear to carry a poor prognosis, the very cellular variety is the most malignant. The classical cylindromatous types are usually more slowly destructive and are not only the more common but are distinguished with the greatest difficulty clinically from more benign lesions.

With the preceding observations in mind, some therapeutic program must be set forth. It must surely be emphasized that initially these are benign appearing, uncharacteristic malignant neoplasms. This should be always in mind when a salivary gland tumor is identified. The awareness of this type of tumor implements the importance of a quick section examination of a tumor at the time of operation.

When a definitive diagnosis has been arrived at, a decision upon the extent of operation must be made:

1) When major nerve palsies are present, the nerve trunk has been involved and the nerve is sacrificed.

2) In the absence of palsy the nerve may be preserved provided the tumor does not lie in immediate juxtaposition to it.

3) Total parotidectomy would seem imperative. This is an infiltrating tumor.

4) The incidence of neck-node metastases is variable in the case reports in the literature and varies from none to 33 per cent. (This percentage is taken from *autopsy material* of patients dying of metastatic tumor.) It would appear that lymph nodes are an alternative way of spread but not the common one. Neck gland resection, then, is obligatory only when palpable, suspiciously positive nodes are present.

While radiation therapy does not appear to have any pronounced effect upon this tumor in the prevention or control of recurrences, its possible benefits as an adjuvant to surgical treatment may be well advised.

Discussion

The reasons for presenting this small, uncommon but distinctive group of tumors appears to me obvious. Because of the large preponderance of benign tumors which appear in the major and minor salivary gland structures, one is frequently at a loss as to how forcefully and urgently he should advise surgical removal. This is so primarily because of the facial palsy that may result from operation—in our experience the immediate postoperative incidence after removal of the benign mixed tumor from the parotid area is in the region of 15 per cent. Only about one-third of these, or 5 per cent, will be permanent. This is a harsh outlook but becomes more serious and grim when one has to deal with malignant neoplasms. This concern is greatly minimized, obviously, when one has to deal with these neoplasms in the other salivary gland regions. It does seem likely that such sacrifice can be minimized if the lesion is attacked when small and discrete and long before nerve invasion makes further sacrifice mandatory.

A second peculiarity of this neoplasm is its propensity to metastasize to lungs and bone. Pulmonary metastases are much the commoner but perhaps the more worrisome because of their likelihood to remain silent for a long period. Like all neoplastic pulmonary metastases, they result ultimately in increasingly severe symptoms and death.

Finally, the local pattern of activity of this tumor may be quite bizarre. Unlike most neoplasms in the parotid salivary gland area, a mass may not be the first evidence noted by the patient. One individual's case history may be illustrative. This man of 50 years had had a parotid tumor removed 17 years prior to his second admission to the hospital. The first evidence of recurrence was a sensation of "drawing" of his facial muscles. This was followed shortly by a total facial paralysis. At the time of his admission with this sign, he was unaware of any recurrent tumor in the area. He had extensive pulmonary metastases upon this admission, and his death two and one-half years later from these extensive pulmonary metastases was the final sequel.

Summary

No attempt has been made to discuss salivary gland tumors in general, but the peculiarities of one small, frequently devastating group of these are described. This group of cylindromatous tumors has commonly a most typical histologic picture, but one often most confusing and innocent-appearing until it is seen under the microscope. It is hoped that awareness of this lesion will lead to a prompt and energetic and well planned attack upon all salivary gland tumors, particularly those in the parotid area.

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POLIO FOUNDATION FELLOWSHIPS

September 1st and December 1st are the current deadlines for applications to the National Foundation for Infantile Paralysis, 301 East 42nd Street, New York 17, New York, for postdoctoral fellowships in research and academic medicine or in the clinical fields of rehabilitation, orthopaedics and preventive medicine. Applications for fellowships in the medical associate fields of physical therapy teaching and occupational therapy teaching should also be filed by these dates. A spring date of March 1 is also provided.

Financial support of the Fellow varies according to his previous education, his professional experience, marital status, and number of dependents. Compensation to the institution is arranged according to the program undertaken. For a full academic program, tuition and fees are allowed; for other programs, a sum not to exceed $1,250.00 per year (includes tuition) is provided.

All awards are made upon recommendation of the appropriate National Foundation Fellowship Committee. U.S. citizenship is required, but those who have filed a petition for naturalization will be considered. Partial fellowships are available for qualified veterans to supplement G.I. educational benefits.

Applications must be received by March 1 for consideration in May, September 1 for consideration in November, and December 1 for consideration in February.

ARTICLES OF INTEREST

THE MALPRACTICE INSURANCE PROBLEM

EDWARD S. STAFFORD, M.D. AND WILLIAM E. GROSE, M.D.*

Although this report was published in the Transactions issue (September 1957) of the Maryland State Medical Journal, the Editor is republishing it, as it is a most thought-provoking study of the subject and merits wide distribution.

During the past few years there has been increasing attention directed to malpractice by both the medical profession and the lay public. A large amount of space in many of the medical journals has been devoted to this subject, and it has been much discussed at medical meetings. In addition, there have been numerous articles in lay publications. Here in Maryland there has been a noteworthy increase in the number of malpractice suits. Because of this heightened interest and concern, the Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland appointed a special committee to consider the subject of malpractice and to make a report to the Society.

Malpractice is defined as a breach of duty on the part of a physician. Thus, in order to prove malpractice, it must be shown in court that the physician has been negligent. Occasionally the issue may be clear-cut. Much more often, however, the issue of negligence is a matter of viewpoint and opinion. It should be pointed out, furthermore, that once such an issue is brought before a court, the court, whether by a judge or by a jury, must render a decision one way or the other. It is out of the uncertainty arising from these circumstances that physicians and insurance carriers are sometimes led to make settlements rather than to risk contesting the issue.

According to a letter to the members of the Baltimore City Medical Society from the President of that Society, eight malpractice suits were instituted in the courts in 1955 in Maryland.† This figure, rather high in contrast to the one or two cases per year of a decade ago, is indeed a matter for concern. But, on the other hand, when one reflects that physicians are human beings, the same figure could be interpreted as evidence of a marvelously low rate of negligence on the part of the practicing physicians of this State. It is well to clarify one's thinking along these lines. When a physician purchases malpractice insurance, he is purchasing protection against the financial loss resulting from an unfavorable decision in a suit brought against him for malpractice. One wonders if it would not be more sensible for the patient, who is the one taking the greater risk, to purchase insurance against negligent or ineffective medical care?

Except in certain areas and except in certain special branches of medicine, there has not actually been much increase in the number of suits brought for alleged malpractice. Nevertheless, the insurance rates have been increased over the country for all physicians. This is chiefly the result of the very large sums which have, in the last few years, been awarded to the parties adjudged to be injured.

In making these staggering awards the jury may consider that a substantial portion goes to the plaintiff's lawyer. Or its members may be influenced by a personal dissatisfaction with a particular doctor; or they may be giving vent to a feeling that doctors make too much money. It is difficult to assess in monetary values either

* Dr. Stafford is the Chairman and Dr. Grose a member of the Committee to Investigate the Malpractice Insurance Problem appointed by the Council of the Medical and Chirurgical Faculty of Maryland.

† In 1957, according to information received, aid in defense for malpractice was requested by four members.

human life or suffering. That this has been a major preoccupation of humanity since antiquity is attested to by the Bible. The Old Testament method of handling such matters, e.g. "an eye for an eye" was outmoded, in theory at least, by the Christian doctrine of turning the other cheek. It would seem that the latter doctrine has not been widely enough accepted, or perhaps it does not act as a sufficient deterrent to thoughtlessness or carelessness. In any event, it is now a part of the law of our times that an injury resulting to a person through carelessness or wrong doing on the part of another person is compensable.

Who stands to lose the most from the injury or loss of life? Obviously, it is the injured or potentially dead individual and it might be argued that this is the person who should carry the insurance. Furthermore, if insurance were carried against this risk by the individual really taking the risk—and perhaps life insurance could be arranged to carry provisions for disability in excess of those now carried—one of the most distressing and even vicious aspects of the alleged malpractice racket would be done away with. This concerns the large share, customarily one-third, of the award in a successful malpractice suit which goes not to the injured party but to the successful attorney. Here is an area where efforts by Bar Associations could bring a considerable abatement of the current nuisance.

How many practicing physicians successfully avoid being sued for malpractice? Obviously the only sure method of doing this is not to practice at all. This sounds facetious, but it is apparent that the increasing costs of mounting insurance rates, and the grave threat to reputation in defending malpractice suits may act as deterrents to young men going into practice, particularly in special fields, such as anesthesiology, radiology, and surgery.

It has been pointed out, in a number of recent discussions of the subject of malpractice, that the majority of the individuals bringing suit against physicians do not do so because there is evidence of actual malpractice. Thus, a patient who feels that he has been badly treated is far more apt to bring a suit for malpractice than an individual who feels that he has been conscientiously and carefully treated, no matter what the outcome has been. If this be true, it would seem that the majority of suits brought for alleged malpractice could be readily prevented if the practicing profession would heed more carefully the Golden Rule. Especially apt to bring suit is the dissatisfied patient who is being pressed to pay an exorbitant professional fee. When away from home or office, each physician must take scrupulous care to see that the services of another physician are readily available to his patients.

Authorities on malpractice also stress the fact that careless or critical remarks made by a physician often lead to the institution of a malpractice suit against another physician. No doubt this is true. Every effort should be made by all practicing physicians to avoid public and casual or careless criticism of the efforts and results of their professional colleagues. On the other hand, how are professional standards to be maintained and raised if there is no criticism? The profession must find ways to do its part to protect the public from the unscrupulous or inept.

No physician enjoys being sued, nor does he relish the effect of the attendant publicity upon his reputation and his practice. Nevertheless, it is extremely important that an innocent doctor defend himself. To make a settlement out of court in order to avoid unpleasantness is akin to submitting to blackmail. Insurance companies are in business to render public service and to make money; in a case of dubious outcome, therefore, great pressure may be put upon a physician to agree to a settlement. Unless the physician be doubtful of his own innocence, however, he should insist on court proceedings. His fellow physicians will rally to his support and must be scrupulously honest in aiding the cause of justice. Whitewashing is as dishonest as blackmail.

Finally, it may well be wondered whether or not the very existence of professional liability or

malpractice insurance does not contribute to the problem. It is remarkable in mid-century America how the interposition of a third party between the plaintiff and the defendant alters the conscience of the judge or jury. The latter seem to be quite willing to award large damages, seeming to believe that insurance companies are inanimate and feel no pain. If the defendant, himself, had to bear the entire cost of the damages, it is likely that the judge and jury would feel differently about the size of the amount. Larger awards, if insurance carriers are not frightened out of this field, will necessitate the payment of larger premiums, thus increasing the expenses of all insured physicians. This, in turn, is bound to result in increased cost of medical care to patients.

A number of interesting approaches toward solutions of these problems are currently being made. In California the members of a county medical society have established a Board which investigates each alleged instance of malpractice and delivers an impartial report. It is said that this has been of great help to judges and juries, to injured patients, to insurance carriers, and to innocent physicians. The American College of Surgeons has established its own professional liability insurance plan for its membership. This organization feels that its Fellows constitute a group of well-trained and able surgeons and, therefore, that the incidence of successful malpractice suits against these will be much lower than is currently the case for all who operate. If this be true then, by this plan, there will be a gradual lowering of the rate charged.

There is, however, no single, simple solution. There will always be some suits because some accidents seem unpreventable and because there are among every doctor's patients a number who are of abnormal mentality. It is believed that conscientious attention to the practice of medicine, continued efforts to keep abreast of the progress of medicine, and careful observance of the needs and rights of others will help to reduce to a minimum the number of suits instituted for alleged malpractice. Patients rarely sue a doctor whom they like.

(Bibliography may be seen in the Faculty office).

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WHAT HAS HAPPENED TO NURSING?

AMOS R. KOONTZ, M.D.

Even the most casual observer, if he has lived long enough, is cognizant of the difference in the attitude of nurses today from that of, say, thirty years ago. The attitude of the average nurse has changed not only with regard to her feeling for her patient, but with regard to the doctor who takes care of the patient. Happily, this is not universally true. Some nurses today are just as fine as any nurse ever was. To these every doctor takes off his hat and bows, acknowledges his dependence upon them, and is happy to relate what a pleasure it is to work with them. Such nurses do their work cheerfully and with a smile. They make life pleasant not only for the doctor, but much more importantly, for the patient as well. My remarks here, it will be obvious, are not directed at them. They are, however, pointedly directed at those nurses who, when asked to take an order or help with a dressing, display boredom and often exhibit annoyance. Their attitude towards their patients is just as improper.

What has brought about the change in attitude

and the obvious laxity found in such a large number of nurses today? Undoubtedly part of it is due (and I believe a large part) to the creeping socialism which has pervaded our land since the middle 1930's. The political philosophy has been one of laissez faire, and our people have been taught that they owe nothing to anyone but themselves. We have been living in an era of "handouts" and "give aways." Thrift and initiative have been supplanted by the doctrine of "let Uncle Sugar do it for you." This doctrine of irresponsibility has changed the very character of our people. No longer are they willing to work hours "above and beyond the call of duty" for the good of the whole. On the contrary, they have been indoctrinated with the idea of doing as little as they can "get by with." A whole generation of our youngsters has been brought up under a system of political philosophy as foreign to that of our fathers as an American field mouse is to a Bengal tiger.

Another reason for the change is the recent tendency to shift nurses from their primary duty—that of the bedside care of patients—to professors of nursing or high-grade administrators. Does the patient benefit from this? Absolutely not. It must be remembered that the only reason for hospitals is the care of the patient. The patient is the central figure. Doctors, nurses, laboratory and x-ray technicians, orderlies and maids, and all the rest of the hired help are accessories after the fact. Once the patient is forgotten in the effort to establish a nursing bureaucracy, the hospital is failing in its primary objective. The present day insistence on the part of some hospitals that nurses must have degrees in order to have any position of responsibility is in common parlance "the bunk." Some of the best nurses I have ever seen had no more than a high school education before entering training, and some of the best supervisors I have ever known come in the same category. But they have the human touch, understand patients, and know how to take care of them. They also know what to do in an emergency if a doctor is not around, and every doctor is delighted for them to do what is necessary, whether they have an order for it or not.

In case any reader of this article should not understand what I mean when I talk about the deterioration of a sense of responsibility as well as of polite manners among nurses, I will cite a few examples which came to my notice during the week before this was written.

I entered the Chart Room on one of the main floors of one of our best hospitals recently and no nurse was available. I rang for one and still none appeared. Finally, a pupil nurse leisurely sauntered into the Chart Room. I said, "Will you take an order please?" She replied, "Huh?" I repeated my request. This time she understood me but made no reply whatsoever. However, she did condescend to saunter slowly and deliberately over to the desk and take my order. But all the time she exuded boredom and annoyance. When she had finished writing the order and I had signed it, I said, "Thank you." Her reply was "Uh huh."

The same day, on another floor of the same hospital, I approached the nurse in charge, who was sitting at her desk, to leave an order. The special nurse of another patient, at the same time, approached the head nurse and began talking glibly about some inconsequential matter relating to her patient. She saw that I was standing there waiting to leave an order but it made no difference to her. She walked right in front of me and stood between me and the head nurse and continued talking for some little time. Finally, the head nurse deigned to look up (of course without getting out of her seat) and said, "Can I help you, Dr. Koontz?", whereupon I left my order. Also whereupon the aforementioned special nurse continued her glib and inconsequential conversation.

In the same hospital, a few days previous to the above mentioned incidents, I went on one of the floors between 5:00 and 6:00 P.M. and found that a patient needed a drug which I knew was not stocked on the floor and which I doubted was

in the pharmacy. At any rate, I knew the pharmacy was closed. I asked one of the floor nurses (a graduate) to call a nearby drug store and have the drug sent in for my patient, explaining that I knew the pharmacy was closed and that at any rate the pharmacy probably did not have the drug; also explaining carefully that I wanted my patient to have the drug that night. Having had previous sad experiences with such requests, I was careful to make sure that the nurse understood exactly what I wanted and was also careful to get an affirmative answer to my request. She promised faithfully to take care of it. When I went on the floor again about 11 o'clock the next morning, I found that the nurse had made no attempt whatsoever to get the drug. Her excuse was that she didn't think that the supervisor would let her order it from the drug store. She hadn't even taken the trouble to ask the supervisor for permission to order it from the drug store! This was such a flagrant violation of everything that makes for a well run hospital and the proper care of patients that I decided to report the incident to the Director of Nurses, but found that she was away on vacation. I tried to see one of her assistants, who was in charge during her absence, without success. I also tried the next day and was told that the assistant was "taking refreshments." I gave up with the feeling of "Oh, what's the use?"

I went into the same hospital early on a Monday morning and asked a graduate floor nurse "Did Mrs. Blank get straightened out yesterday"? Her reply was, "I have been off two days and nobody has told me so I don't know." She made no effort to find out for me and treated me with more indifference than if I had been an autumn leaf falling from a nearby tree.

A fifth incident happened recently in another of our very best hospitals. My patient had a special nurse. The nurse and I were standing by the patient's bedside going over the incidents of the previous 24 hours and I was asking her about certain things that had happened during that period, when someone called her to the door. She left me abruptly right in the middle of a sentence without even excusing herself. I went out in the corridor and found her talking to a man who, she said, was an old patient who wanted to speak with her. She could easily have deferred this social visit for the two or three minutes required for me to finish my conversation with her and to give her instructions about my patient. But no, the little social call took precedence over her professional duties.

On the same day, in the same hospital, I was operating on another patient and was just putting in the last subcutaneous suture preparatory to closing the skin when the circulating nurse came up and asked, "Can you get along without a scrub nurse for the rest of the operation as your nurse is supposed to go off at 11 o'clock and I have no one to replace her"? I looked at the clock and found that it was exactly 11:00 o'clock. Of course I said, "yes," but wondered why the scrub nurse could not have stayed five minutes longer until the wound was closed and the dressings applied. Maybe she had to go to a class in chemistry, or maybe she belongs to a union.

I hope that some of the nurses I have described in this article will read it, will recognize the error of their ways, and will turn over a new leaf. If they do, my hat is off to them and all is forgiven. If they do not, they will probably dislike me for what I have said about them. For that I do not care a rap. If people consistently and willfully neglectful of duty liked me, I would feel as sullied as a virtuous woman improperly approached.

Such incidents as those related above demonstrate clearly the lack of discipline that is the rule rather than the exception in the nursing profession today. Gone are the days when nurses invariably made rounds with doctors, and when a nurse always got on her feet when a doctor entered the Chart Room and answered his questions with "Yes, Dr. Blank" or "No, Dr. Blank." An army cannot be effective without discipline, and neither can a hospital. Such laxity as has been pointed out here has a deleteri-

ous effect on the care of patients, even if the nurses who are guilty of the breaches are capable of excellent nursing.

I have recounted here what I consider to be some of the general causes of the present situation. There are apparently also more specific causes, such as the tendency for national regimentation of the entire nursing profession. Some of the older nurses, who are also much concerned with the present situation, deprecate this tendency. Training shools cannot get proper "accreditation" unless they meet certain standards. One sees fewer and fewer pupil nurses on the floors these days. They are busy taking courses some place. If Osler's bedside teaching is good enough for medical students, why isn't it good enough for nurses also? Formerly almost all the training was gotten at the bedside as "on the job" training." Certainly a certain amount of classroom work is necessary, but the tail shouldn't wag the dog.

Of course it would be fine if the remedy would come from the nursing profession itself. However, it must be remembered that the nursing profession is an ancillary profession and that the object of the nurse is to help the doctor with his work. The time has arrived when that help is often given grudgingly, sparingly, and accompanied with bad manners. If the nursing profession itself doesn't remedy the situation, it is high time for the doctors to act. Doctors run the hospitals and there could be no training schools without their sanction and help. This being the case, it seems to me entirely proper for the doctors to exercise enough control to see that the present deplorable situation is remedied.

1014 St. Paul Street
Baltimore 2, Maryland

Poll on Social Security Medical Care. Rep. Harold L. Collier (R., Ill.) who comes from Chicago has polled his constituents on such things as financing medical care for all those under social security. He reports this response: seventy-three per cent were opposed, twenty-six per cent were in favor and only one per cent had no opinion. The Forand bill provides hospitalization and surgical services for all persons eligible for social security payments and for their dependents. On the question of should mandatory social security be expanded, the response was forty-seven per cent yes, forty-eight per cent no and five per cent no opinion.

Equally interesting was the response to the question, do you favor government scholarships for higher education or some method such as tax benefits for individuals and business. Twenty-six per cent favored federal scholarships, sixty-eight per cent were for some tax mechanisms and six per cent had no opinion.

A.M.A. Washington Letter

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, May 23–June 19, 1958

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT. AND SERUM	MEASLES	MENINGOCOCCAL INFECTIONS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County	21	—	64	1	68	1	10	—	—	—	2	1	1	7	—	1	e-1	3
Anne Arundel	4	—	2	—	15	—	7	—	—	—	1	—	—	3	—	1	—	—
Howard	—	—	2	—	—	—	—	—	—	—	—	—	—	4	—	—	—	—
Harford	1	—	1	—	5	—	1	—	—	—	—	—	—	4	—	—	—	1
Carroll	—	—	—	—	—	—	—	—	—	—	—	—	1	3	—	—	—	3
Frederick	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	m-1	1
Washington	—	—	—	1	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Allegany	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Montgomery	10	—	66	1	92	—	—	—	—	—	8	—	—	4	1	2	m-1	1
Prince George's	—	—	11	1	27	—	—	—	—	1	—	—	—	6	—	—	e-1	5
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles	—	—	1	—	—	—	—	—	—	—	—	—	—	2	—	—	—	1
Saint Mary's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Cecil	—	—	—	—	—	—	—	—	—	1	—	—	—	1	—	—	—	—
Kent	—	—	—	—	4	—	—	—	—	1	—	—	—	1	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	2
Dorchester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Wicomico	—	—	—	—	4	—	1	—	—	—	1	—	—	2	—	8	—	—
Worcester	—	—	8	—	21	—	20	—	—	—	—	—	—	1	—	—	—	1
Somerset	—	—	—	—	12	—	—	—	—	—	—	—	—	—	—	1	—	—
Total, Counties	36	0	157	4	248	1	39	0	0	3	12	1	2	43	1	48*		23
Baltimore City	116	0	287	5	180	0	36	0	0	0	10	0	2	67	20	547		8
State																		
May 23–June 19, 1958	152	0	414	9	428	1	75	0	0	3	22	1	4	110	21	595		31
Same period 1957	151	0	40	7	171	2	237	4	0	3	68	0	45	132	13	542		50
5-year median	302	1	62	40	460	3	290	2		5	81	1	35	170	17	620		36
Cumulative totals																		
State																		
Year 1958 to date	1287	3	2014	54	5818	14	337	0	0	3	411	3	42	793	109	3201		538
Same period 1957	1178	1	205	74	770	17	1727	4	0	4	703	1	148	835	103	3214		359
5-year median	2885	7	484	174	3793	28	1754	6		7	1282	8	175	1012	113	3390		430

e = encephalitis.
m = meningitis, other than meningococcal.
* = total includes cases reported by State Hospitals or Institutions.

1957 SEMIANNUAL MEETING IN RETROSPECT

LESLIE E. DAUGHERTY, M.D.

Journal Representative, Allegany-Garrett County Medical Society

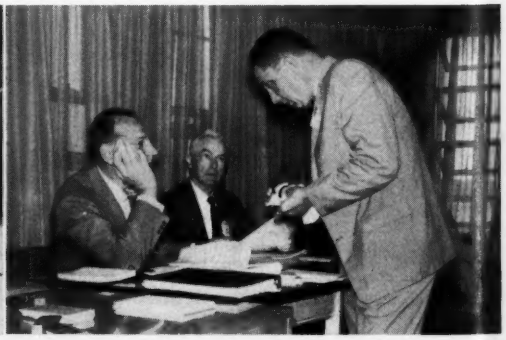
Ocean City, Maryland, again was the location for the Semiannual Meeting of the Medical and Chirurgical Faculty in September, 1957.

After a busy summer, Asian Flu, etc., a glorious vacation at the shore does something that nothing else can do. The family, children and grandchildren drink in the sunshine, ocean breezes and the magnificent food—such a feast—the clam bake.

There was an informative business session, which was followed by the general meeting, at which our President, Dr. C. Reid Edwards, made an outstanding address.

A fitting climax to the summer's work!

"From the Floor"



"What concerns us, concerns the A.M.A."

Your Invitation to the Semiannual Meeting of the

MEDICAL AND CHIRURGICAL FACULTY

FRIDAY, SEPTEMBER 12, 1958—OCEAN CITY, MARYLAND

The Committee on Scientific Work and Arrangements has planned another interesting and entertaining meeting for Friday, September 12, 1958, at the Commander Hotel in Ocean City.

HEADQUARTERS—COMMANDER HOTEL

BUSINESS SESSIONS

COUNCIL ..... Thursday, September 11, 8:00 P.M.
HOUSE OF DELEGATES ..... Friday, September 12, 9:30 A.M.

SCIENTIFIC and SOCIAL PROGRAM—FRIDAY, SEPTEMBER 12

SCIENTIFIC SESSION ..... 12:30 P.M.

Recognition and Treatment of Anemia. **C. Lockard Conley, M.D.,** Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore.

CLAM BAKE ..... 2:30 P.M.
DANCE ..... 9:30 P.M.

Make your plans now to attend the Semiannual Meeting with your family and enjoy the attractive social functions and informative scientific meeting. Members are invited to attend the meeting of the House of Delegates.

FOR DETAILS SEE YOUR PROGRAM, WHICH WILL BE MAILED THE LATTER PART OF AUGUST

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Annual Meeting of the Medical and Chirurgical Faculty

Our genial Secretary, Dr. Carlton Brinsfield, took time off at the Annual Meeting in April to see the Exhibits at the Alcazar. There he met many of his old friends and classmates, especially a former resident of Cumberland and the Allegany-Garrett County areas, Dr. John E. Legge.

Dr. Brinsfield remarked that the Exhibits always were very good, but that this year, due to the increased space, they were especially good. There were fifty-two exhibits. You could see the latest book, the newest antibiotic, or the latest and best surgical appliance or instrument. The exhibits were convenient to the Assembly Room where the Scientific Lectures were held and one could stop a moment or an hour, if he chose.

Dr. John E. Legge, formerly of Oakland; later of Cumberland, and now of Baltimore City—fourscore plus in years, very active physically and mentally alert—seemed to be as keenly interested today in what's new as he ever was. Dr. Legge has just finished a long tenure of office as a member of the State Medical Examining Board. May he continue to attend these Annual Meetings for many years to come.

Personals

Dr. Leo H. Ley, Jr. was appointed Chairman of the Mental and Physical Health Program of the Allegany County Youth Commission at its last meeting which was held in the Central Y. M. C. A. in Cumberland.

Dr. Calvin Y. Hadidian, of Cumberland, attended the American Association of Chest Surgeons meeting held in Boston recently.

Dr. A. Talbott Brice, of Jefferson, was appointed

General views of the Exhibits at the Annual Meeting of the Medical and Chirurgical Faculty—held at the Alcazar in Baltimore on April 16, 17 and 18, 1958

DR. CARLTON BRINSFIELD AND DR. JOHN E. LEGGE visit the Exhibits at the Annual Meeting

Counsellor to the Allegany-Garrett County Medical Society for 1958.

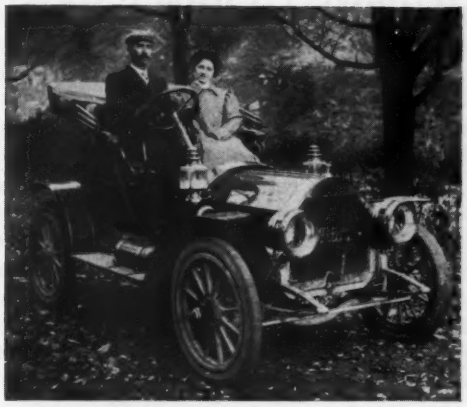
Dr. Abdul Hashim, of Cumberland, addressed the nursing staff of the Allegany County Health Department on the care of infants suffering from malnutrition.

Dr. Leland Ransom was elected President of the Amateur Radio Club of Allegany County.

BARTON MEDICINE

Barton, Allegany County, derives its name from the many towns called Barton on Humber, Lincolnshire, England. The name means "grain fields" and that is what the George's Creek Valley really was in the early days.

One hundred and five years ago (1853) the town of Barton was laid out by a William Shaw and his brother, Dr. Benjamin B. Shaw, who later was its first resident physician. Its earliest name was "Fire Meads"; then it was called "Ball's Good Luck," and finally it was named "Barton" from William Shaw, Sr., a Methodist preacher who had migrated from Barton, England. Until that time, the only physician in the Valley between Westernport and



DR. AND MRS. SAMUEL A. BOUCHER IN 1909
(Dr. Boucher was the last physician to practice in Barton)

Frostburg was Dr. Lewis F. Klipstein. He was in the lower-most end of the Valley, near Westernport. By 1814 Dr. Klipstein and the Doctors Samuel P. Smith and John M. Lawrence—the latter two located in Cumberland—covered the entire Valley between Frostburg and Westernport and Big Savage Mountain to Pompey Smash (now Vale Summit).

The second physician to settle in Barton was Dr. J. K. Berkebeil. He practiced there from 1856 to 1861.

Dr. Watson J. Piper (who was born in 1842 in Flintstone, Allegany County, twelve miles east of Cumberland) studied medicine under Dr. Samuel P. Smith of Cumberland and graduated from the University of Maryland in 1865. In 1866 he located in Barton for the practice of medicine.

In 1893, Dr. William A. Osler, Dr. William S. Halsted and many of the physicians of the Medical and Chirurgical Faculty, who were attending the Semi-Annual Meeting in Cumberland, journeyed by horse and buggy to the Valley where they visited the iron mines.

In one hundred and five years, there have been exactly eight physicians who have practiced in Barton. Other physicians were Doctors A. Hagerty, John William Crawford, C. R. Fourche, George E. Hotchkiss and John H. McGann. The last physician to practice in Barton was the late Samuel A. Boucher. He located there in 1888 and practiced until his death, in 1941, at the age of eighty. During the last ten years of his life he made five violins with his own hands.

Today Barton is without a physician. This territory is covered partially by doctors from Lonaconing, Frostburg and Westernport.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.
Journal Representative

At its regular meeting on December 17, 1957, the Executive Board considered letters from Mr. Manrodt, Chairman of the Blood Donor Project of the Council of Churches and one from Mr. Wehr, Chairman of the Baltimore Chapter, American Red Cross. They asked the City Medical Society to endorse the plan to establish a Red Cross Blood Bank in Baltimore. Since a Committee of the Society had already studied this problem, it was moved to table the matter until the Committee's report could be reviewed.

Dr. Lawrence M. Serra wrote calling attention to unnecessary speeding and siren blowing by ambulances. This problem had been studied previously by a committee under the chairmanship of Dr. Alan Woods, Jr. Dr. Woods' committee recommended that no action be taken against the noise and speed, after its interview with Mr. Henry Barnes, Traffic Engineer of Baltimore City. Some Executive Board members expressed the opinion that it was primarily private ambulances that offended. The Board voted to write to the private ambulance companies about this complaint and urge that they police their own problem.

An obstetrician wrote of disservice by the city ambulance service. A patient of his delivered suddenly at home and he called a city ambulance for emergency help. The ambulance (on emphatic orders from the central dispatcher) took the patient to the nearest hospital. The hospital to which she was taken was not the one at which she was registered. The physician then put the mother and newborn in his own car and took them to the institution to which she could be admitted. The Board felt that the physician was in error in calling a public ambulance for a private patient.

The Treasurer, Dr. Kimberly, already a member of the Medical Faculty's Committee for National Emergency Medical Service, was designated to also represent the City Society on this Committee.

Dr. I. Ridgeway Trimble, Chairman of the Faculty Committee wrote that he had a meeting in January and asked that a representative of the City Society be named.

Drs. S. M. Greenberg and J. Mason Hundley, Jr., were approved for emeritus membership on sending notice that they were retiring from practice.

At the same time, Dr. Merrell L. Stout, emeritus member, wrote signifying his intention to act as consultant to a group interested in physiotherapy and inquiring if this would change his membership status. The Board voted that this constituted active practice of medicine and that under those circumstances Dr. Stout was no longer eligible for emeritus membership. The Board voted that his membership status should be changed to Active Member.

Dr. Robert Kimberly reported that since the cancellation of the Washington National Insurance Company's policy, he had been seeking actively for a favorable policy to replace it. He had at this time narrowed to three the available field and hoped to have data to submit to the Board soon. He wants to get a non-cancellable policy for the members if possible.

Dues were discussed in the light of possible increase. This seems imminent since the Faculty equalized City and County members' dues at $50.00 per year. The Faculty has notified us that a charge would be made for use of its facilities. The sum of twenty thousand dollars a year has been mentioned. After a definite figure is reached, the Board felt it would have to have the approval of the membership before dues could be increased. The City Society's dues are still ten dollars a year. Changed costs would require increasing it. An individual suggested that this would be a good time, perhaps, to look for a building of our own. Physical separation of the two organizations was recommended by the last management analysis firm. A suitable structure, possibly one of the downtown motion picture theatres currently going into insolvency, might provide just the auditorium, comfortable seats, administrative offices, rest rooms, and meeting place that our City Society would like to have. Possibly the twenty thousand dollars a year rental that we are to be asked to pay the State, in addition to our regular dues to City and State Societies, could, in a few years, buy us our own building. This suggestion was promptly disregarded. The sentiment prevailed that the Faculty needs us and we cannot desert it now, while it is in financial difficulties.

Dr. Huntington Williams requested support of a Resolution in favor of a formulary for use of the Medical Care Clinics. After certain stipulations, approval was voted.

* * * *

The Regular Meeting of the Baltimore City Medical Society was held Friday, January 3, 1958 and called to order at 8:30 by our new President, Dr. Whitmer B. Firor.

Introduced as the Baltimore City Society's official guests of the evening were Dr. C. Lee Randol, Secretary-Treasurer, and Dr. Charles F. O'Donnell, Delegate of the Baltimore County Medical Society.

President Firor then announced that possibly none of us were legally members of the Society because the constitution clearly requires that all new members must be elected by written or secret ballot. And truly the memory of man turneth not to the time when our elections were not by acclamation. The list of candidates was presented. We were advised to write "all" on the face of the list, or to circle any whom we wished to challenge, and pass our 'ballots' to the tellers. So all were elected by *written* ballot, at least. Since we had to write our names to establish our membership status and right to a vote, they were hardly secret.

A Resolution was presented by Dr. Huntington Williams, Commissioner of Health for Baltimore City, as approved by the Executive Board. The Resolution urges the Health Department to keep the costs of the "Medical Care Program at as low a figure as is compatible with efficient medical care" and to "Approve the use of the special Formulary designed for this program, with exceptional other uses when approved by the City Medical Care Section." In the discussion regarding the Resolution, Dr. Russell Fisher (whose patients do not need a Formulary), warned that physicians should be careful that they are not committing themselves to use ONLY the drugs in the Formulary. He urged that they make provision for use of exceptional drugs when necessary, and that they be sure to be well informed about the machinery for getting them. Dr. Geraghty, a proponent of the Resolution, stated that special drugs will be and can be obtained with permission of the Medical Care Section of the City Health Department, Dr. J. Wilfred Davis, Chief. The motion to support the Resolution was then carried.

The sixty-five members present were then treated to a splendid Panel Discussion on Alcoholism. Dr. Lewis P. Gundry, Associate Professor of Medicine, University of Maryland Medical School was moderator. In his opening remarks he passed lightly over acute alcoholism, as a problem similar to that of any other acute intoxication with which doctors and hospitals have to cope, and devoted his presentation to the tremendous problem of chronic alcoholism. He gave a basic definition that chronic alcoholism is "loss of control over drinking so that life becomes unmanageable because of alcohol." Confusion that sometimes occurs when alcoholic delirium and bromidism (from Bromo Seltzer for the hangover) overlap was pointed out. Treatment in a hospital was depicted as the only way to initiate recovery. Complete withdrawal, from the start of treatment, was recommended. Barbiturates and anticonvulsants can be used for support over the five to fifteen days of transition. After that psychiatric care, if possible, Alcoholics Anonymous if the patient is unable to afford psychiatry, and an antabuse "umbrella" may be given. Complete sobriety is the only way for such people.

Dr. Isadore Tuerk, Consultant in Psychiatry, University of Maryland School of Medicine and Superintendent of the Spring Grove State Hospital, next spoke of the psychiatric aspects of alcoholism. He outlined the need to adapt therapy to the personality of the patient and pointed out the "enormous oral dependency" in all. Compulsive individuals did best with antabuse, he felt. Depressive reactions seemed to respond better to reflex conditioning types of therapy. Hypnotherapy seemed more effective with the chronic anxiety pattern. "Milieu therapy," or the healthful environment provided by hospitalization without specialized therapy, seemed best for those who could stand tension but could not stand quick transitions. He agreed that complete sobriety was the only way.

Dr. Lester H. Gliedman, Chief of Alcohol Research Program and Assistant Professor of Psychiatry, the Johns Hopkins Medical School, presented "Some Family Factors in Chronic Alcoholism." The extended list of agencies—City, State, Federal, and philanthropic—he read off as operative in the alcoholism problem in Maryland was most impressive. It was also most enlightening regarding the gigantic proportions of the problem. From his point of view, family factors, both cultural and sociological, were most important as showing the setting within which the alcoholism occurs and the dependency on family values. Drinkers, he stated, went through three stages: Social, pseudo-social, and chronic alcoholic.

Marriage made it important to consider the family as a unit. Combined husband and wife therapy was more effective than either singly, although the forty-five in the study group decreased to nine at the end of the observation period. He felt that marriages among and to alcoholics were at infantile levels emotionally, and wife-instigated to satisfy needs of their own. Such wives developed their own problems again when the husbands stopped drinking.

"Community Programs Relevant to the Problem of Alcoholism" was the theme of the concluding speaker, Dr. Robert E. Thomas, Chief of the Mental Hygiene Division, Maryland State Department of Health. Dr. Thomas reverted to the difficulty of agreeing on a definition of what constitutes alcoholism or even whether it is a disease or a symptom. He noted as "Primary Preventive" the importance of the general education program on all levels: national, state, and city; the attention to spouse and family of the alcoholic; and the decisive obligation of the schools. Of "Secondary Preventive" importance is the great need for statistics, epidemiology, community programs, and for research "into all aspects." He cautioned practicing physicians to insist on a practical payment plan and to resist the infantile dependency which seems to make these patients universally unwilling to pay for treatment.

Two of the questions addressed to the Panel were especially significant for the practical physician. One asked if the physician, knowing his patient's alcoholism, should in any way feel responsible for reporting the fact to the Commissioner of Motor Vehicles. The Panel agreed that the honorable physician was NOT so obligated. Possibly because it was felt that the Commissioner could not legally act on such information only; that he could remove licences only for cause.

The second question concerned the risk of suicide in chronic alcoholics. When and how can a physician tell when an alcoholic is suicidal? How can his physician prevent it and know when to warn the family? Dr. Tuerk seemed to sum up the Panel's thought when he tersely stated that "Alcoholism *is* suicide. It just takes three to ten years to do it, that's all." That's how it differs from other methods.

Refreshments (*non* alcoholic) were graciously served by the Woman's Auxiliary after the meeting. Many lingered to enjoy them and discuss the papers.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.
Journal Representative

The April meeting of the Baltimore County Medical Association was held at the Sheppard and Enoch Pratt Hospital in Towson, Maryland. Following a a superb luncheon, Dr. Joseph D. Lichtenberg, Medical Co-ordinator at the hospital addressed the meeting on "The Importance of the Family's Response to the Patient's Mental Illness."

After the scientific talk, Dr. William Pillsbury gave the annual Presidential address. Dr. Pillsbury said that, as President, he had the opportunity to see an over-all picture of medical practice in Baltimore County. He feels that we are losing the tradition of "fee for service." Demands are being made on the profession that heretofor have been unheard of—free polio clinics, Asian flu vaccine administration, cancer detection clinics, well baby clinics, school clinics and many others. Dr. William H. F. Warthen, of the Baltimore County Health Department, has been most cooperative in helping the Medical Society to stem the tide. However, he, too, is under pressure. Dr. Pillsbury said that the School Health Coordinating Council has been very helpful in improving the health program in the schools.

Dr. Pillsbury suggested that the county physicians could help the medical profession by joining groups and organizations in which the voice of the medical profession could be heard. He also said that the number of grievances being brought to the attention of the medical society are increasing and that we should be firm in our convictions and support the high ideals of medicine. From the public relations angle, it is better to have grievances handled in committee, rather than by the county or State society, as was done in a recent case.

Attendance at meetings has averaged about 50 members. This represents only about 25 per cent of our membership. The new constitution requires attendance at two meetings a year. However, forced attendance does not make a good member and certainly is not the answer. Meetings must be made more attractive. A broader variety of medical topics and occasional evening meetings may help.

DR. CLARENCE MCWILLIAMS

Dr. Pillsbury concluded by introducing the new officers: Dr. Clarence McWilliams, President; Dr. J. Morris Reese, Vice-President; and Dr. John E. Gesner, Secretary-Treasurer. These men will serve until June 1959.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

The April meeting of the Frederick County Medical Society was held on the 22nd at the Francis Scott Key Hotel. The speaker of the evening was Dr. Julian Krevens, Associate Professor of Medicine, Johns Hopkins Medical School. He gave a most interesting as well as informative talk on "Blood Transfusions." His discussions of the after speech questions were particularly valuable.

Several of the Fort Detrick medical men attended and were well rewarded in hearing Dr. Krevens.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

DAVID S. CLAYMAN, M.D.

Journal Representative

Since our last report, the matter of polio inoculations has come up for a very spirited discussion. At a special meeting, held on April 17th, the Executive Board, in conjunction with interested lay persons representing the AFL-CIO, discussed the current status of mass polio inoculation programs initiated by community groups. This meeting pointed up the fact that the AFL-CIO Community Services Committee had been active in our county, as well as in the entire metropolitan area, in setting up mass polio inoculations at $1.00 per head. At these sessions neighborhood doctors had been asked to make the inoculations without compensation. Our president and other representatives of our Society stressed the fact that its members were not interested in payment but were vitally interested in the item of professional liability. Under the Union plan, the physician would be solely responsible for the defense of malpractice suits, though working under conditions in which he had no control over the vaccine he administered, the sterility of needles and syringes, etc. At the conclusion of the meeting it appeared that the Union found the Society's suggestions acceptable as to future programs of this type. They agreed to work through the health department so that this agency could assume the maximum amount of professional liability which would be involved in the program.

At a meeting of the full Society, on May 6th, this matter was again discussed in its entirety and our Society is now on record as favoring the following procedure in such cases:

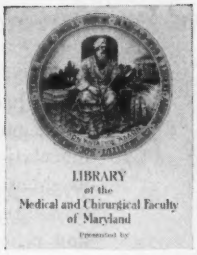
1. Our county health department has jurisdiction over all preventive medicine in Prince George's County.

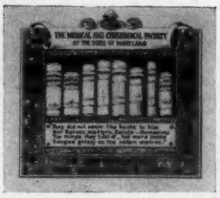
2. When members are contacted by someone in our community to participate in a mass inoculation program, we are to direct that person to call the health department.

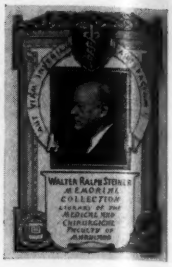
3. The health department will employ the necessary medical personnel to administer the inoculations.

4. Physicians may be requested by the health department to enter into temporary employment for this purpose and physicians may offer their services to the health department for any particular community.

It has been found that since this arrangement went into effect, the Union people are working harmoniously with the medical society and the health department. Although neither the medical society nor the health department feels that this is the ideal solution, we do feel that this is an acceptable compromise whereby the medical profession still retains control and leadership over a pressing medical problem.







Library

Louise D. C. King *Librarian*

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *Ibn Tibbon*

RECENT ADDITIONS TO THE LIBRARY

Allan, J. G., Principles & practice of surgery, 1957
Allfrey, V. G., Cellular biology, 1957
Alvarez, W. C., Live at peace with your nerves, 1958
Anscombe, A. R., Pulmonary complications . . . , 1957
Artz, C. P., Treatment of burns, 1957
Bacon, J. M., Ulcerative colitis, 1958
Behrendt, H. J., Chemistry of erythrocytes, 1957
Black, D. A. K., Essentials of fluid balance, 1957
Bremer, J. L., Congenital anomalies of the viscera, 1957
Chatfield, P. A., Fundamentals of neurophysiology, 1957
Cobb, Stanley, Fundamentals of neuropsychiatry, 1958
Craig & Faust, Clinical parasitology, 1957
Dahlin, D. C., Bone tumors, 1957
Dalcq, A. M., Introduction to general embryology, 1957
Dandy, W. E., Selected writings, 1957
Danowski, T. S., Diabetes mellitus, 1957
Davis, H. A., Principles of surgical physiology, 1957
Dripps, Robert, Introduction to anesthesia, 1957
Dunton, W. R., Occupational therapy, 1957
Edwards, W. S., Plastic arterial grafts, 1957
Ellinger, Frederick, Medical radiation biology, 1957
Equen, Murdock, Magnetic removal of foreign bodies, 1957
Evans, F. G., Stress and strain in bones, 1957
Fairhall, L. T., Industrial toxicology, 1957
Field, M. G., Doctor and patient in Soviet Russia, 1957
Fields, Theodore, Clinical use of radioisotopes, 1957
Fishbein, Maurice, Medical writing, 1958
Forster, F. M., ed., Modern therapy in neurology, 1957
Furlong, Ronald, Injuries of the hand, 1957
Gardiner, M. D., Principles of exercise therapy, 1957
Gifford, S. R., Textbook of ophthalmology, 1957
Greenfield, J. G., Atlas of muscle pathology, 1957
Grollman, Arthur, Clinical physiology, 1957
Grollman, Arthur, Pharmacology & therapeutics, 1958
James, A. H., Physiology of gastric digestion, 1957
Johnson, Julian, Surgery of the chest, 1958
Krantz, J. C., Jr., Pharmacologic principles of medical practice, 1958
Lawler, S. D., Human blood groups & inheritance, 1957
Le Quesne, L. P., Fluid balance in surgical practice, 1958
Levine, S. A., Clinical heart disease, 1958
Lippman, R. W., Urine & the urinary sediment, 1957
Lisser, Hans, Atlas of clinical endocrinology, 1957
Lovejoy, E. C. P., Women doctors of the world, 1957
MacEachern, M. T., Hospital organization and management, 1957
Marr, J. P., Pioneer surgeons of the Woman's Hospital (N. Y.), 1957
Martin, Hayes, Surgery of head and neck tumors, 1957
Maximow, A. A., Textbook of histology, 1957
Merton, K. K., Student physician, 1957
Moore, D. C., Regional block, 1957
Muchrcke, R. C., Lupus nephritis, 1957
Mullett, C. F., Bubonic plague and England, 1956
Nadas, Alexander, Pediatric cardiology, 1957
Novak, Emil & E. R., Gynecologic & obstetric pathology, 1958
Palmer, E. D., Clinical gastroenterology, 1957
Paton, R. T., Atlas of eye surgery, 1957
Quick, A. J., Hemorrhagic diseases, 1957
Rebuck, J. W., ed., The leukemias, 1957
Robinson, G. C., Adventures in medical education, 1957
Rodriguez, J. A., Atlas of cardiac surgery, 1957
Rosenthal, S. R., BCG vaccination against tuberculosis, 1957
Sargent, W. W., Battle of the mind, 1957
Semon, H. C. G., Atlas of the commoner skin diseases, 1957
Short, O. L., Rheumatoid arthritis, 1957
Snapper, I., Bone diseases in medical practice, 1957
Steele, J. D., Surgical management of pulmonary tuberculosis, 1957
Strauss, M. B., Body water in man, 1957
Tracy, J. E., The doctor as a witness, 1957

Maryland
SOCIETY OF PATHOLOGISTS INC.
PAUL F. GUERIN, M.D., *President*
ROBERT D. SOLOMON, M.D., *Secretary*
Sinai Hospital, Baltimore 5, Md.

AN ADEQUATE BLOOD SUPPLY—THE CLINICIAN'S RESPONSIBILITY

Are you helping your hospital blood bank operate efficiently? The major problem in this operation is the replacement of blood so that an adequate supply is on hand at all times. In order to accomplish this, donors must be obtained on a continuing basis. Blood can be obtained from members of local organizations who are motivated by humanitarian reasons and a sense of civic responsibility, health consciousness and loyalty to their organization's projects. This motivation is often not sustained; therefore, blood from these sources is helpful but is not a solution to the problem.

Strict adherence to the blood bank replacement policy is essential for its efficient operation. For the most part, this blood must be obtained from relatives and friends of the patient. Who must have the responsibility of seeing that this is accomplished? The blood bank is a service facility. Its primary responsibility is to collect, process and dispense blood. The clinician who requests blood for transfusion must assume the responsibility for a balanced bank; too often such responsibility is shirked. He needs to realize that every unit used must be replaced. Frequently, in small blood banks, a replacement ratio of more than one-for-one is required in order to maintain an adequate supply.

An additional problem is created by "blood indigent" patients who have no relatives or friends in the immediate neighborhood. In such cases, they are requested to pay for the blood used so that professional donor blood can be purchased as a replacement. An explanation of this procedure, by the clinician to the patient, can go a long way towards preventing misunderstanding in this area.

The clinician can materially help his blood bank by telling the patient that blood will be needed for treatment and that he must obtain donors to replace the blood used. If each clinician will do this, and then take the position that his responsibility is ended only when the replacement blood is in the bank, then the most annoying and often serious problem of the blood bank will have been solved.

The Heart Page

Gordon Walker, M.D. – Coeditors – Robert Singleton, M.D.

A SERVICE OF
THE HEART ASSOCIATION OF MARYLAND

CONGESTIVE HEART FAILURE AND THE NEWER ORAL NON-MERCURIAL DIURETICS

W. GORDON WALKER, M.D.

(*Ed. Note—This is the first of a regular series of brief articles covering topics pertinent to the diagnosis and management of cardiovascular disorders. They are intended to provide general information of immediate clinical application with regard to newer developments and current concepts in cardiovascular disease.*)

The management of severe congestive heart failure remains a problem that taxes the ingenuity of the physician. Excluding the cases for which a specific remedy (either medical or surgical) is available, the problem of getting rid of excess sodium is a continuing one that occasionally defies the most vigorous diuretic regimen. Several oral non-mercurial diuretics that promise to be of some value have been introduced recently. Aminometradine (Mictine®) and aminoisometradine (Rolicton®) are aminouracils that increase sodium and chloride excretion following oral administration but tend to loose their effectiveness with continued daily use. Several newer carbonic anhydrase inhibitors as well as other agents have also appeared.

Of these newer oral preparations, the most potent is chlorothiazide.* The effect of this sulfonamide derivative on renal electrolyte excretion resembles the action of mercurial diuretics rather than that of the carbonic anhydrase inhibitors (e.g., Diamox®). The primary effect is a marked increase in sodium and chloride excretion with less marked increase in potassium excretion. Balance studies on markedly edematous patients refractory to mercurials have shown prompt increase in sodium excretion with weight losses varying from 10 to 20 lbs. during a ten day period of administration of this drug in a dosage of 2 grams a day. A randomized, double blind comparison between this agent and a parenteral mercurial in a group of out-patients with congestive heart failure showed that chlorothiazide in dosages of either 1 or 2 grams daily was superior to weekly injections of 2 cc. of a potent mercurial diuretic agent. It is also significant that chlorothiazide retains its effectiveness during prolonged periods of daily administration in contradistinction to the carbonic anhydrase inhibitors and other oral diuretics. Indeed, it has the unique property of continued effectiveness in the presence of both acidosis and alkalosis, differing in this regard from both mercurials and carbonic anhydrase inhibitors. It is also effective in increasing sodium excretion in the presence of fairly severe renal insufficiency. Thus, this drug appears to be the most potent oral diuretic agent currently available.

Such potency proves to be a two-edged sword however. The fact that it maintains its effectiveness in the presence of both alkalosis and acidosis means that severe electrolyte disturbances may be produced unless the patient is watched carefully during therapy. The most common changes seen are mild hypochloremia, mild hypokalemia, and elevation of plasma bicarbonate. In most patients these are not associated with symptoms and reverse themselves when the drugs are discontinued. Because of the dangers of hypokalemia in heart failure, routine administration of potassium has been recommended.

A more alarming disturbance is the occasional appearance of very marked metabolic acidosis. The mechanism of this disturbance is unclear. To date it has been seen only in patients with mild or moderate renal insufficiency. When noted it has been of rather sudden development (but not necessarily at the beginning of therapy) and associated with a rising blood urea nitrogen. The cause of this disturbance is unclear; the degree of renal insufficiency per se does not seem to be the determining factor since the majority of patients with renal insufficiency respond with a good diuresis and do not exhibit this disturbance. The possibility that this is a direct

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Blue Cross - Blue Shield

PHYSICIANS AND BLUE SHIELD

DENWOOD N. KELLY*

At the recent Annual Conference on Blue Shield Plans, much of the time was devoted to the subjects of standards for desirable coverage and physician participation in Plan affairs. Some 160 doctors attended the conference, either as trustee representatives of their respective Blue Shield Plans or as interested observers. While it would be a natural assumption that any physician who attended such a conference, per se, would be interested in Blue Shield affairs, the depth of this interest and the desire to have other physicians share it were so obvious as to bear comment.

Initially, the following major premises were made:

1. Blue Shield was created to enable the medical profession to meet its responsibility to the community; specifically, to enable people in the lower and middle income brackets to prepay the unpredictable and unbudgetable costs of necessary medical care.

2. The provision of prepaid medical services involves the interests and welfare of the entire community. While the most obvious need for prepaid services is among the lower income groups, the entire community now wishes, and should be able, to purchase prepaid care.

3. Furthermore, the dynamics of Blue Shield are such that it must be supported by the entire community—or at least by a balanced cross-section of the community—if it is to be available on attractive terms to the least favored segments of the community which most need prepayment protection.

4. Either Blue Shield is sponsored and approved by the medical profession, or it is not.

5. If Blue Shield *is* so sponsored and approved, then the medical profession has an inescapable responsibility to see that Blue Shield meets the reasonable expectations of the people and that it does credit to the reputation and traditions of the profession.

One of the most important conclusions reached was *that a service benefit plan should have a maximum family income limit high enough to include potentially a substantial majority (75% or more) of the families in its area of operation.*

It was emphasized that service benefit income levels cannot be profitably considered except in relation to these other essential elements of a Blue Shield Plan:

1. A realistic income level must be related to a schedule of payments that is based upon normal average medical fees for professional services rendered for families having incomes within that income level.

2. Payments adjusted to a high income level may be found to be too high for families in the lower income ranges; hence consideration may be given to multiple income levels and schedules of payments.

3. Any schedule of payments, to be acceptable to the medical profession on a full-payment basis, should be established only in consultation with, and with the advice and approval of, the local medical profession.

4. The payment structure of the Plan must be supported by subscription rates sufficient to assure payment of the full schedules, yet moderate enough to be acceptable to the subscribers and to keep the Plan in a favorable competitive position.

Fundamental to these considerations are certain underlying essentials of Plan structure and organization:

1. Any Blue Shield Plan should have an organic structure that gives the medical profession a controlling voice in all matters of medical policy, in selecting the medical representatives of the Boards and Committees, in setting schedules of payment, in adjudication of disputes and grievances relating to cases and payments, and in all administrative procedures affecting professional relations.

2. Counterbalancing its controlling voice in the medical aspects of Plan operation, the profession, individually and collectively, should recognize and accept a feeling of direct *responsibility* for the Plan —for maintaining its good name, for supporting its objectives, and for promoting its acceptance and understanding on the part of the people.

3. Each Plan should strive at all times to increase its scope of services, in order to provide as broad a range of services as the local medical profession is willing to provide through the mechanism of the Plan.

*Assistant Director, Maryland Medical Service, Inc.

Continued on page 386

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. DAVID S. CLAYMAN, *Auxiliary Editor*

PRESIDENT'S ANNUAL REPORT

April 16, 1958

MRS. DAVID S. CLAYMAN

This is the report of the activities and accomplishments of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland for the year 1957-1958. To select the highlights of the year has been a difficult process, because I find so many wonderful things have happened. My only hope is that nothing is being omitted from this, my report to you.

First, I am happy to tell you of the new addition to our family of component auxiliaries. Carroll County was formally organized in March 1958 with nine members, Mrs. Shipley, Mrs. Caples and Mrs. Clayman represented the State Auxiliary. They immediately selected officers for the year and named their delegates for the Annual Meeting. The following officers were elected: Mrs. James T. Marsh, President; Mrs. Morrell Masten, President-Elect; Mrs. Wilbur Foard, Treasurer; and Mrs. William B. Culwell, Corresponding Secretary. Many thanks to Mrs. Chepko and Mrs. Moulton who accepted the responsibility of serving as temporary chairmen.

The "Today's Health" and the "Bulletin" Chairman reports that 178 subscriptions of each publication were sold in Maryland.

By proclamation of Governor McKeldin of Maryland, March 30th was designated as "Doctor's Day." The Baltimore City Auxiliary gave a donation of $50.00 to A.M.E.F and $25.00 to the Student Aid Fund in honor of Doctor's Day. A dinner dance was held at the Green Spring Inn. The "Doctor of the Year" was chosen and presented at the dinner. All doctors received red carnations. Another county gave a delightful cocktail party at the Indian Spring Country Club. This was sponsored by Peoples Drug Stores. Three county hospitals received arrangements of flowers in memory of deceased members of the Medical Society. Other auxiliaries celebrated by giving luncheons and presenting red carnations to the doctors. All auxiliaries received publicity during the entire week of March 30th, through the media of press, radio and the church. It is our fervent hope that Doctor's Day 1958 brought to physicians all over the State a well earned tribute for devotion to their profession.

Information on the Jenkins-Keogh Bill was sent out. No further steps were taken as Congress has deferred action on most health bills.

The Woman's Auxiliary pages of the Maryland State Medical Journal contained many interesting reports from our component auxiliaries and committee chairmen as well as a number of other interesting articles.

This year two issues of our State Newsletter—"Hygeia Filiae"—"Handmaidens to Health" have gone out. This publication is sent to the wife of every doctor who is a member of the State Faculty as well as to the other State Medical Auxiliaries. It has carried news of the component auxiliary activities and has tried to bring your officers and committee chairmen closer to you.

American Medical Education Foundation has been well supported this year. I am proud to report that every component auxiliary earned something toward this fine cause. Every Auxiliary participated in the sale of $1.00 earrings, earning for A.M.E.F. fifty cents on each pair sold. Baltimore City also sold Christmas cards for this worthy project, also one county held a rummage sale, and earned $653.75.

The "Dramatic Reading Group," (sponsored by the National Association of Mental Health, Inc.) presented a play on a psychiatric theme entitled "What Did I Do?" Each of the three times the play was given, Dr. and Mrs. Irving Taylor went along to interpret it and to answer questions from the audience. One school for mentally retarded children received childrens books, toothpaste, tooth brushes, combs, etc. The State Mental Hospital was found to need street clothes for patients ready to be paroled. The City Auxiliary was most enthusiastic about the project and I am happy to say that all the county auxiliaries are cooperating.

There are 75 organized Future Nurses Clubs in Maryland. The clubs are in 17 counties and in Baltimore City. Each club operates independently

and includes girls who are interested in all types of medical careers. There were six 3-year nursing scholarships given, one monthly allowance, one loan to a student nurse and two loans of $500.00 each were awarded to two students in their last year in medical school. In addition, many scholarships have been given by other organizations through the influence of the local auxiliaries, including several from local medical societies. The girls in the Future Nurses Clubs have varied programs. Several clubs have raised money each year for a scholarship to be used by one of their members. One club raised $230.00 for the proposed Carroll County Hospital. Many club members spend week-ends and vacation time doing "Pinkie" duty. In addition, many clubs have entertained and taken gifts to, and helped at nursing homes, children's hospitals and county health centers. The president of the Westminster High School Club was chosen "State Good Citizen" in the annual contest sponsored by the Maryland Society, Daughters of the American Revolution. Donna Stonesifer is president of the Senior Class, a member of the National Honor Society, and wishes to become a missionary nurse. The Future Nurses Clubs have planned to have their Convention at the Milford Mill High School, Pikesville, on Saturday, May 17, 1958.

The movie "A Car Of His Own" was shown at one of our Board meetings. Since then the movie has been and is being shown in high schools throughout the State. It is most interesting and encourages driver training in high schools. President Eisenhower feels so keenly on this subject that he has organized the "President's Committee For Traffic Safety." The entire country was divided into four parts, putting Maryland in the eastern region. This group met in Atlantic City on March 11th and 12th of this year. At the General Meeting we were told that the purpose of the conference was to get citizen support to put over the Traffic Safety Program. The group from Maryland met later in the day and after a long discussion came up with the following goals to work for in the coming year:

(1) Develop statewide citizen support programs. This means that every organization should become immediately cognizant of the number one cause of death in young people and to organize themselves to promote safety and to cooperate with a state wide group with the same interest.

(2) Legislation for periodic re-examination of all drivers and meeting national visual standards. I understand that Maryland is one of the few States that does not have such legislation. This would remove from the road those people so physically handicapped as to render them safety hazards.

(3) Provision of additional State police to meet minimum strength requirements.

(4) Provide an adequate driver education program. This refers especially to promotion of our high school driver program.

(5) Establishment of a full-time safety education supervisor in the State education department.

(6) Enact legislation for chemical tests. It seems that alcohol has an important role in causing accidents and in order to get convictions it is necessary that irrefutable evidence be submitted. This evidence would serve to exonerate the innocent as well as to convict the guilty.

(7) Support adherence to modern highway engineering standards. This refers particularly to the construction of new roads free of traffic hazards.

Goals number four and six were insisted upon by the representatives from your organization. We should feel extremely proud of this

For the first time, our auxiliary has a display among the medical booths at this convention. Dr. Eastland, president of the Medical Faculty, has been most cooperative and we are deeply appreciative.

We have had unusually fine cooperation from press and publicity. It is necessary for the Auxiliary and for the individual members to BE GOOD, to DO GOOD, and to TELL THE PUBLIC ABOUT IT. I want to express my heartfelt appreciation to the entire staff of the Executive Office for their steadfast support and sincere cooperation.

As your President, I attended the National Convention in New York, giving the annual report. I also attended the Presidents and Presidents-Elect Meeting in Chicago; as well as the Annual and Semi-Annual Meetings of the Pennsylvania State Auxiliary; the Annual State Meeting in Delaware and the President's Committee for Traffic Safety Meeting in Atlantic City. I have visited each of the component auxiliaries at least twice. On two occasions it was my pleasure to install their new officers. I represented the Woman's Auxiliary to the Medical and Chirurgical Faculty at the Future Nurses Clubs Convention and attended several of their district meetings.

Although it meant traveling to Baltimore almost every day for several weeks, I enjoyed being in the play "Know Your Auxiliary." I hope we do this sort

of thing again soon. I have held six Board meetings and the Semi-Annual Meeting in Ocean City, the latter a general meeting. In addition, I endeavored to get some of the State committee chairmen to hold private meetings with their component chairmen so that they could gain a better insight into what they are doing and why. About four chairmen complied with my request and I earnestly believe it helped.

To my officers and committee chairmen I wish to express my heartfelt thanks for their support during a wonderful year—one containing small problems, big accomplishments, good public relations and best of all, true and lasting friendships. I say "Orchids To You," my officers and committee chairmen; *Orchids* to each of you who served so faithfully and gave so unstintingly of your time, efforts and abilities. I shall never forget you.

NEW OFFICERS

At the Annual Meeting held on April 16, 1958 at the Sheraton-Belvedere Hotel, the new officers of the Woman's Auxiliary to the Medical and Chirurgical Faculty were elected and installed. Since then, the president, Mrs. Shipley, has also announced the Committee Chairmen for the coming year.

Officers and Chairmen of Committees

The following officers were elected for 1958–1959: President, Mrs. E. Roderick Shipley, Hanover; President-elect, Mrs. D. Delmas Caples, Reisterstown; First Vice-President, Mrs. E. Paul Knotts, Denton; Second Vice-President, Mrs. David J. Boyer, Hagerstown; Third Vice-President, Mrs. John O. Robben, Kensington; Fourth Vice-President, Mrs. Martin E. Strobel, Reisterstown; Recording Secretary, Mrs. Otto C. Brantigan, Baltimore; Corresponding Secretary, Mrs. Raymond V. Rangle, Baltimore; Treasurer, Mrs. Emil G. Bauersfeld, Chevy Chase; Parlimentarian, Mrs. Thomas A. Christensen, College Park.

Chairmen of the Standing Committees are: Organization—Mrs. D. Delmas Caples; Membership—Mrs. John M. Rehberger; Program—Mrs. Thomas E. Wheeler; Finance—Mrs. John G. Ball; Revisions and Resolutions—Mrs. Albert E. Goldstein; Doctor's Day—Mrs. Gerald W. Le Van; Historian—Mrs. Raymond V. Markley; Auxiliary Editor (Maryland State Medical Journal)—Mrs. David S. Clayman; Newsletter—Mrs. John P. Haberlin; Mental Health—Mrs. Irving J. Taylor; Hospitality—Mrs. Whitmer B. Firor; American Medical Education Foundation—Mrs. Martin E. Strobel; Public Relations—Mrs. Mrs. John O. Robben; "Today's Health" & Bulletin—Mrs. David J. Boyer; Press and Publicity—Mrs. E. Ellsworth Cook; Key and State Legislation—Mrs. H. Hanford Hopkins; Members-at-Large—Mrs. E. Paul Knotts; Recruitment—Mrs. D. Delmas Caples; Civil Defense—Mrs. Charles H. Williams; Convention Arrangements—Mrs. William S. Stone; Safety—Mrs. Stuart D. P. Sunday.

Over 400 Future Nurses of Maryland met in their Sixth Annual Conclave on Saturday, May 17, at the Milford Mill High School, Pikesville, Maryland, when annual elections were held. Dr. Louis A. M. Krause addressed those present on Medicine and the Bible. A fashion show on Hair Styles for Nurses was given by the Maryland Chapter of National Hairdressers and Cosmetologists Association, Inc. Mrs. E. Roderick Shipley, President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland presented the Award for the Outstanding Future Nurses' Club of Maryland to the Surrattsville High School group. Members of the Auxiliary acted as hostesses.

At the meeting were groups from as far west as Cumberland and Oakland and as far east as Salisbury. One group stayed overnight because of the distance. Present also was a group from Washington, D. C. The purpose of the convention was to interest girls in becoming nurses and thus to help alleviate the nursing shortage throughout the State and county.

During the current year five new clubs have been organized so that now there are 75 Future Nurses Clubs scattered throughout the State. Each club receives a charter from the Maryland League for Nursing, has its own projects, studies aspects of nursing, takes trips to hospitals and medical museums, assists in giving polio and flu vaccine in schools and works in health clinics on weekends and after school hours. During vacation, many members take the six-week pre-nursing course in hospitals, known as the "Pinkie" course.

The group, at this meeting, voted to send $100.00 from its treasury to provide books for Korean nursing schools.

Mrs. Charles Williams and Mrs. D. Delmas Caples, of Reisterstown, completed the arrangements for the affair, including luncheon. Assistance was provided by parents from the Reisterstown area.

Over 20 hospitals had exhibits outlining the schools of nursing programs, both practical and registered.

FUTURE NURSES MEET IN CONVENTION

Shown discussing problems of the Future Nurses' Clubs of Maryland are Mrs. Charles Williams, co-chairman of the Auxiliary's committee to handle this event; Karen Kinsinger, newly-installed president; Anne Weidemeyer, outgoing president; and Mrs. D. Delmas Caples, co-chairman of the Sixth annual conclave. The event was held on Saturday, May 17, at the Milford Mill High School, Pikesville

New officers for the coming year, who were installed by Mrs. Caples, include Karen Kinsinger, president, Grantsville; Jean Bransfield, vice-president; Kay Strohm, recording secretary; Patti Batchelor, corresponding secretary—all from Reisterstown—and Patti Friend, treasurer and Sue Herschberger, historian—both from Grantsville.

AUXILIARY TO PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

President's Annual Report, 1957–1958

MRS. HENRY R. WOLFE

The officers and members of the Auxiliary to the Prince George's County Medical Society worked together most cooperatively in an effort to make 1957–1958 a favorable year. The Auxiliary opened the year's program officially with a luncheon meeting in September at the Prince George's Golf and Country Club. State Auxiliary President, Mrs. David S. Clayman, was guest speaker and gave an informative talk on Auxiliary objectives.

In December, during our Christmas meeting, we were able to earn a $7.50 contribution to A.M.E.F. through the sale of jewelry. The Program Chairman arranged an interesting and timely program for that day—a gift wrapping demonstration.

The Ways and Means Committee worked hard on our fund-raising project, a lovely dessert card party. This took place at the Prince George's Golf and Country Club on January 24, and was a great success. Our profit amounted to $300.00.

In February, a decision was made to award two nurse scholarships in 1958. The group voted to increase the amount of the scholarships to $400.00 because of the higher costs of training. A luncheon was given at Prince George's General Hospital to honor the girls receiving the scholarships, their parents and the Auxiliary. At this luncheon, the Medical Society also presented two scholarships.

On March 25th, a Mental Health dramatic presentation of the play "What Did I Do"? was given, to which many representatives of other local organizations were invited.

"Doctor's Day" was celebrated on March 31st with a buffet luncheon at Prince George's General Hospital in honor of our physicians. A red carnation was pinned on each doctor as he entered the hospital.

We are proud to say that we now have 50 paid up members. The "Address Book of Medical Society Members" was revised and sold, bringing in a profit of $43.60. Eight subscriptions to "Bulletin" and 33 subscriptions to "Today's Health" are reported.

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Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Venereal Disease Control

Two interviewer-investigators, Mr. Warren McFague, Health Program Representative and Mr. George G. Bailey, Public Health Adviser, have been assigned by the U. S. Public Health Service to the Baltimore City Health Department's Division of Venereal Diseases. They will assist Mr. Joseph P. Conte, also a U. S. Public Health Service worker, who came in December 1956 to aid the City Health Department in its venereal disease control work.

Since there has been an upward trend in the number of newly reported cases of syphilis in persons under twenty-five years of age in Baltimore in recent years (308 cases in 1957, 280 in 1956 and 236 in 1955) the three Public Health Service representatives were requested so that the City Health Department might put into use a new method of venereal disease control for syphilis, known as the "cluster interviewing technique." Formerly the venereal disease control technique involved the investigation of only sex contacts of a known case. The new cluster interviewing technique, a method of rapid venereal disease control, not only investigates sex contacts but also associates of the known case. This is done on the assumption that the so-called associates are also likely to have venereal disease. By utilizing this sweeping method of interviewing and detection, the location of the total population segment infected, or possibly infected, can be more rapidly achieved.

Huntington Williams, M.D.

Commissioner of Health

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4. Each Plan should attempt to keep pace with changes in the economy within its area, and should follow a policy sufficiently flexible to assure that it certainly will be making its benefits—in terms of prepaid professional services—available to at least as great, if not a greater, proportion of its people as it now does.

Medical sponsorship must be real, medical approval must be active and medical interest must be genuine and tangible if Blue Shield is to succeed. Maryland Blue Shield has been fortunate in its relations with the medical profession—it does have the sponsorship, approval, and interest of the State Medical Society and the members thereof. Our Plan structure and organization are such that the medical profession does have a dominant voice in deciding Plan policies of a medical nature.

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Among the Auxiliary's contributions this year have been the following: $100.00 to Prince George's General Hospital for medical journals; $10.00 to the Mental Health Society; $37.50 for 25 six-month subscriptions of "Today's Health" to County public schools.

The Auxiliary to Prince George's County Medical Society was honored this year by the presentation of a beautiful inscribed gavel—the gift of Mrs. David S. Clayman, State President. We are proud to have as State President a former president of the Auxiliary and take this opportunity to thank her again for her much appreciated gift.

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nephrotoxic effect similar to that seen occasionally with other sulfonamides cannot be excluded at present. Hematuria has not been observed, however, and the fact that fairly prompt improvement occurs with cessation of the drug casts some doubt upon this possibility. An alternative is that these changes may be due to progressive renal insufficiency as a consequence of sodium depletion.

Thus chlorothiazide appears to be the most potent and effective oral diuretic available at present. It promises to be of great value in the management of severe congestive failure and out-patients with heart failure. However, because of its potency, it should be used with care and patients receiving this drug for prolonged periods should be watched closely for electrolyte disturbances.

Dept. of Med. Johns Hopkins Hospital

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* (DIURIL®)